VOLUME ONE · NUMBER ONE · SPRING 1980

HUMAN DEVELOPMENT

The Jesuit Educational Center for Human Development

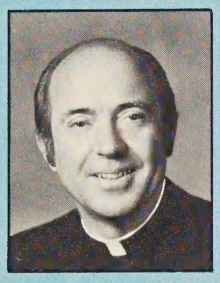
THIS ISSUE

Apostolic Health

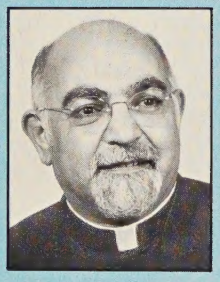
Depression — 1980

Experience and Spiritual Direction

Stresses of Leadership



EDITOR-IN-CHIEF **James J. Gill, S.J., M.D.,** is a priest, physician, and psychiatrist. While working at the Harvard University Health Services during the past 12 years, Father Gill has served as psychiatric consultant to superiors of many religious congregations, formation personnel, and spiritual renewal centers throughout the world. During recent years, he has taught at the University of San Francisco, Loyola University (Illinois), St. John's University (Minnesota), the U.S. Air Force Chaplains School (Alabama), and the Graduate Theological Union (California). A member of the California Province of the Society of Jesus, Father Gill grew up in San Francisco and was ordained to the priesthood there in 1957. He has published more than 50 papers on topics related to religion, human development, community life, and psychiatry.



SENIOR EDITOR **Angelo D'Agostino, S.J., M.D.,** is a priest, physician, psychiatrist, and psychoanalyst. Father D'Agostino is a member of the staff of the George Washington University Medical School in Washington, D.C., and is Chairman of the American Psychiatric Association's Committee on Religion and Psychiatry. During the past decade, he has served as Director of the Center for Religion and Psychiatry of the Washington Psychiatric Institute Foundation and as a faculty member of the Washington Theological Coalition, Washington, D.C.

ASSOCIATE EDITOR **Linda Amadeo, R.N., M.S.,** is a nurse whose clinical specialty is psychiatry. A graduate of Boston College, Miss Amadeo has counseled and taught religious men and women in the United States, Canada, Europe, and Asia. She has served on the faculty of the Stritch School of Medicine at Loyola University in Chicago, the summer theological faculty at the University of San Francisco, and at St. John College in Cleveland. She has directed numerous workshops and programs for religious superiors, formation personnel, and spiritual directors.

The quarterly journal, Human Development (ISSN 0197-3096) is published by LeJacq Publishing Inc., 130 John St., New York, N.Y. 10038 for The Jesuit Educational Center for Human Development. This is a nonprofit organization concerned with interpreting the wealth of information in psychology, medicine and psychiatry impacting on the work of persons engaged in spiritual guidance and counseling. Subscription rate $16.00 U.S. & Canada. All other countries: $23.00. Single copies $5.00 in the U.S. & Canada. All other countries $6.00. Second class postage application pending in New York City and additional mailing offices.

HUMAN DEVELOPMENT

VOLUME ONE · NUMBER ONE · SPRING 1980

CONTENTS

Editorial Board

Human Development

EDITOR-IN-CHIEF
JAMES J. GILL, S.J., M.D.

SENIOR EDITOR
ANGELO D'AGOSTINO, S.J., M.D.

ASSOCIATE EDITOR
LINDA D. AMADEO, R.N., M.S.

Le Jacq Publishing Inc.

MANAGING EDITOR
CHARLES BLACKWELL

ART DIRECTOR
JESSICA MITCHELL

CIRCULATION DIRECTOR
N. JOAN DYSKO

EXECUTIVE VICE PRESIDENT
RAYMOND C. BODINE

PUBLISHER AND PRESIDENT
LOUIS F. LE JACQ

CURIA PRÆPOSITI GENERALIS
SOCIETATIS IESU
ROMA - Borgo S. Spirito, 5

January 22, 1980

Dear Father Gill,

I wish you and your associates great success in achieving the goals of your new journal, HUMAN DEVELOPMENT, and those of your Jesuit Educational Center for Human Development.

Your efforts and the dedication of the men and women working with you will provide a most valuable service to those who are guiding and supporting the religious development of countless persons, young and old, all over the world.

With best wishes for God's blessings on all of your good works to foster human growth in the Lord, I commend myself to your Masses and prayers.

Sincerely yours in Christ,

Pedro Arrupe, S.J.

—MARYKNOLL—SISTERS

Maryknoll, New York 10545
Tel. (914) 941–7575

To the Editors—Friends!

One of the more refreshing insights in the area of human development in the past twenty years has been the integration of psychological, physical and spiritual identity, growth, and meaning in life. Insight, however, precedes motivation and change. And as we also know from our sometimes painful experience, long standing attitudes and behaviors change slowly, despite early intellectual acceptance of certain realities.

This quarterly, HUMAN DEVELOPMENT, comes as an important response to the growing demand for more assistance with the process of integration of basic dimensions of human life. I, for one, am delighted and grateful to welcome this new journal. Congratulations!

The work itself is a holy one collaborating with the call of both the Old Testament (Sirach XVII,23) and the New—with the call of Jesus Himself (John X,10) to life in its fullness.

Hopefully the contributors to HUMAN DEVELOPMENT will offer us a challenging exchange of ideas relevant to our times in ministry . . . times that require of us great personal autonomy . . . times that call us to true friendships as persons in far more integrated communities of women and men who are capable of breaking out of the rigid categories of clerical/lay, religious/secular, male/female. Thus, the particular challenge to HUMAN DEVELOPMENT now is to help us to choose life more responsibly for ourselves, and to respond to one another in a community of friendship unpreoccupied with self-serving categories and distinctions.

I look forward to an enriching exchange in these pages. Thank you!

Sincerely,

Maria Rieckelman

Maria Rieckelman, M.M., M.D.

January 28, 1980

APOSTOLIC DELEGATION

UNITED STATES OF AMERICA

3339 MASSACHUSETTS AVENUE, N.W.
WASHINGTON, D. C. 20008

Reverend James J. Gill, S.J.
Editor-in-Chief
Human Development
130 John Street
New York, New York 10038

Dear Father Gill:

Permit me to extend congratulations to you and all of your associates on the occasion of the publication of the inaugural issue of the quarterly journal, Human Development.

Addressing the special meeting of the College of Cardinals in Rome on November 5, 1979, Pope John Paul II noted that "it is necessary to seek a proper expression of the relationship between the Church and the wide field of modern anthropology and the human sciences, just as Pius XI sought the expression of the relationship between the Church and mathematics and the natural sciences when he set up the Pontifical Academy of Sciences."

Your initiative gives every evidence of responding to the challenge which the Holy Father put forth. If properly utilized, I am confident it will contribute to the development of strong, healthy persons who will be all the more effective in their religious vocations.

Please be assured of my support and encouragement.

With kind regards, I remain

Sincerely yours in Christ,

+ Jean Jadot

Apostolic Delegate

Editorial

Spring Breathes Life into Human Development

Springtime brings signs of new life. Winter's quiet hopes are warmed into being. Silence blossoms and becomes fragrant. An auspicious season, I would think, for the birth of a new publication.

Our reasons for initiating this promising venture and its principal aims are told in the issue's first article, "Human Development Needs You"—a confession made by a 4-million-mile air traveler who is now trying to reach more people by using up typewriter ribbons instead of jet petroleum.

A LOOK AT EDITORIAL CONTENT

You will find, we trust, that the articles in this inaugural issue, just as all that will appear in every subsequent one, represent our firm intent to select topics and points of view that will prove useful to the readership for which *Human Development* is designed, that is, people striving to exert a positive and helpful influence on others in their care, especially by helping them become fully mature and alive.

Our interview with Father William Connolly, S.J., explores his experience-shaped views about the process of spiritual direction. It also gives us a close-up look at the widely known Center for Religious Development, which is housed across the street from Harvard in Cambridge, Massachusetts.

Spiritual growth is related to the vitality of the whole person. Saints, like Ignatius, sometimes learned this at great personal cost. Our "Apostolic Health" article puts into proper ministerial perspective the care of one's health by physical fitness. One of the values of regular exercise (walking, running, etc.) this article suggests is highlighted in our treatment of stress. Since most of our readers are in some ways leaders and in other ways followers, the attention we pay to the inevitable stresses that flow from these roles should, we hope, be useful. This is the first of a two-part article; Part II will appear in our next issue.

Those who are overcome, even briefly, by the stressful conditions and events they experience—particularly the loss of dear ones, job, youth, health, etc.—are often plunged into more or less deep depression. This is thought to be the most common of all the types of emotional distress requiring professional help. But our article looks at the "normal" types of depressed states, not just the pathologic forms. Since those concerned about the development of others often find it blocked by prolongation of such a painful emotional state, we attempted to provide a detailed outline of the signs and symptoms that disclose its sometimes disguised presence. ("Signs," by the way, in medical terminology, are what you can perceive from an observer's vantage point; "symptoms" are what the suffering person notices from his or her perspec-

tive.) Furthermore, to enable religious people who have others in their care to understand better what professional therapists do to help people in depression, we offer in Linda Amadeo's overview article a quick look at the various modes of treatment available. Implied in her contribution is the fact that it generally takes professional competence to aid a person whose depression is deep and ingrained enough to be termed "clinical." Through Amadeo's comments, superiors, spiritual directors, and formation personnel should get a better idea of what it is they are "supporting" when someone in their care is also in treatment.

UPCOMING ARTICLES AND WORDS OF THANKS

At the end of most of the articles we print, as you will see in this issue, we intend to list several books or articles as "Recommended Reading." These are works from which our writers have selected ideas, or which they think might give the reader a chance to explore the topic more broadly or deeply. Some readings are included because, in addition to being instructive, they themselves contain further references to printed materials on the subject.

We seriously considered listing also at the end of each article a series of spinoff topics that we recognize as closely related to the article's content. We thought we might promise to develop these separately in follow-up articles in later issues of *Human Development*. We experimentally started the process with the article on depression. Surprisingly, very little brainstorming after reading it produced in short order a list of nine different topics, all potentially good for future articles, and there could easily be many more that we failed to recognize. But we finally decided to leave it to our readers to tell us what questions, topics, or related issues their reading of our articles provoked. We believe we already have a reasonably good idea of what subjects ought to be considered in this quarterly during its first few issues, but we remain wide open to suggestions. We want you, our reader, to feel that this is your publication at least as much as it is ours.

One final, inevitable question. We know we are addressing a readership of thousands that may include even more women than men. So, in presenting a concept such as clinical depression (which is known to affect three times as many women as it does men in this country), should our writer use throughout the article the pronouns she and her, or keep saying he or she, or repeat over and over he/she, him/her? Obviously, the choice is optional, but consistency seems called for. We decided, with full awareness of and (we believe) sensitivity to the Women's Movement, that we should proceed in the conventional, admittedly chauvinistic, style for the first issues. We can change after that, if our readers prefer. But if you haven't had the experience of reading page after page with every relative, singular, personal pronoun presented in the feminine gender, try reading a book like *Stress, Sanity and Survival* by Woolfolk and Robertson, and see how you feel at the end. Then send us a note and let us know your preference.

So, with this first issue of *Human Development*, a new publishing venture—in springtime—comes to life. We are grateful for this chance to collaborate with the Le Jacq Publishing Company and its very competent, congenial, and experienced people. They have helped us immeasurably to get under way, as have Edward O'Rorke and Edward Brady of New York City, two of our most generous and valuable consultants.

We appreciate beyond words the encouragement you, our reader, will be giving us by considering these spring issue pages. We hope they will prove to be interesting, enlightening, confirming, and provocative of reflection and discussion on your part. Most of all, we hope you will enjoy *Human Development* and ask God in your prayers to help us all make it an instrument He will bless with far-reaching, long-lasting success in contributing to the development of His Kingdom.

James J. Gill, S.J., M.D.

Human Development Needs You

James J. Gill, S.J., M.D.

As a firm believer in that ancient maxim "confession is good for the soul," I feel I owe the reader an explanation of how this new quarterly publication came about. There is more than a little self-protection involved.

For years now, I have been haunted by thoughts that I suspect Dr. Martin Luther King, Jr., would have called a dream. It begins with my gratitude to the Society of Jesus for having given me the chance to go through medical school, internship, and psychiatric training after ordination to the priesthood. Following those ten years came season after season of experiencing repeatedly the elation that I find accompanies each opportunity to share insights with sisters, brothers, lay persons and clergy during courses, workshops, and other programs. Then I found myself trying to imagine what would be the best "next step" to take, as St. Ignatius would say, "for the greater glory of God."

There is also an element of survival entailed. As a psychiatrist on the staff of the Harvard University Health Services, I have been working for 15 years with a great sense of enjoyment and satisfaction among some of the most congenial colleagues one could ever hope to find. I arranged (thanks to Dr. Dana Farnsworth) to work at Harvard on a half-time basis so that I could be free to travel widely and present the programs I felt would allow me to make the best contributions I could, in view of the training and experience I was blessed to get within the diverse but overlapping fields of psychiatry and religion. Having had since childhood a somewhat uneasy feeling about Jesus' not so subtle warning that "from those to whom much has been given, much will be expected," I felt in some sense "called" to travel to Australia, Japan, Taiwan, Korea, Viet Nam, Thailand, India, Africa, Italy, France, Ireland, and England, and then some, where invitations to work and superiors' assignments brought me gladly. The pace has been steady—maybe more accurately unrelenting—year after year. And what has become increasingly apparent to me is the fact that there are just too many seminaries, too many provinces, too many formation houses, and too many dioceses looking for a little help from an itinerant priest-psychiatrist for one to say yes to all the invitations, no matter how attractive or urgent they might appear. Jesuits are taught, in the spirit of our founder, to try continually to discern, with the Holy Spirit's help, which apostolic ventures we should undertake and to remain wide open to every possibility.

One of the strongest recommendations St. Ignatius gave us to guide our decision making is that we should always think in terms of the most far-reaching or widespread good that can be pursued for the benefit of God's people. Consequently, I looked again carefully at the worldwide array of communities and institutions I was being asked to visit, and thus came to realize that there are three groups of religious persons who most frequently seek assistance from me and my brother priest-psychiatrists and priest-psychologists. These are unsung leaders—people making personal contact and exerting considerable influence—who are serving others as religious superiors, formation personnel, and spiritual directors. Life has not become a crisis, generally, for these people themselves. The help they request is usually needed by someone in their care. Most often the problems that arise and call for attention are related to ordinary human growth and development, not to psychopathology. (That is not saying that there aren't occasional times when a community member reaches the "breaking point" and professional help is required.) But what I finally recognized is that the same kinds of problems are being encountered over and over again, everywhere, and most of the distress that is being experienced is preventable.

What can be done to help formation teams, spiritual directors, and superiors all over the world to gain enough theoretical knowledge and the basic

skills to enable them to act effectively in ways that will (1) foster full human development, (2) identify incipient emotional illness, and (3) secure appropriate and adequate treatment when this is required? Certainly there are a number of individuals among those groups of "helpers" who are well trained and equipped to accomplish these aims. But others are, as we all know, called to the task without being given the full preparation they need. Furthermore, there isn't enough time, once the work is taken in hand, to do the reading of books and periodicals that would be required in order to keep up with all the latest useful information from the fields of psychology, psychiatry, counseling, and medicine.

RESPONDING TO A WORLDWIDE NEED

Gradually, with suggestions from many, I sharpened the question: How can I best help religious people in potentially influential positions within their communities to know enough about the art of intervening helpfully in the process of normal human development throughout the full life-cycle, so that they can function as effectively as possible in facilitating the lifelong growth of those the Lord is entrusting to their care?

It seemed logical at this point in my quest to think in terms of a publication of some sort, one that could serve as a vehicle to convey continuously the kinds of information that persons in growth-influencing roles would welcome. A quarterly schedule was thought by many of our religious consultants to be most advisable, at least at the start. It should be in English but available to publishers for translation into other languages. Our advisors also strongly suggested that the price of subscription should be minimal, the enterprise nonprofit, and copies should be sent without charge into Third World countries and communities where paying the full price of subscription would not be feasible. It was recommended, in order to make this possible, that we also seek financial assistance from benevolent foundations.

Human Development has thus come into existence as a project that we believe can respond to an urgent and worldwide need. It is my own hope, and that of my associates in this venture, Father Angelo D'Agostino, S.J., M.D. (Senior Editor), Linda Amadeo, R.N., M.S. (Associate Editor), and our editorial board, that this publication—launched with great vigor, hopefulness, and joy—will provide the content and the forum for exchange you want. We know that in the various parts of the world and among the diversified religious communities that encompass it, many new things are being tried and learned about religious formation, dealing with change, aiding the aging or dying, helping novices and seminarians persevere, resisting "burn out," and the like. We want to hear, too, what you are attempting, what proves helpful, and (perhaps most instructive of all) what fails and why, so that we can pass this information along to all our readers. We want to hear your ideas, your questions, your preferences. We need your recommendations, your comments about what we print that proves helpful; what disappoints, interests, or puzzles you; in sum, about all we write. We also want very much to publish articles you may feel inclined to contribute to *Human Development.* We will be happy to read and respond to manuscripts, as long as they are typed and are previously unpublished, be they very brief or quite lengthy. Let the subject matter and your own judgment determine how long they ought to be. Review a book you want to recommend, if you like, one you think other readers concerned with human development should know about. Or, if you don't feel inclined to write an article or review, please don't hesitate to send a note to us to let us know what topic or issue you would want us to cover.

FUTURE PLANS AND OFFERINGS

Under our umbrella title, *The Jesuit Educational Center for Human Development,* we will be announcing in the near future some workshops and programs that we intend to offer in various parts of the world as an extension of *Human Development.* We are hoping (and praying, of course) for foundation help in this regard too. Eventually, we also hope to make available personal consultation by phone, visit, or in writing, for those who want more specific information about various topics or issues we raise. As soon as we are able to expand our staff a little, we will announce the inauguration of this service.

Human Development is the name we have given our publication because it seems capable of suggesting what is our most deep and heartfelt concern: the fulfillment of Christ's intention in coming among us so that all may have life, and have it "more abundantly."

SPIRITUAL

IT BEGINS WITH EXPERIENCE

The editors of Human Development *feel privileged to have the opportunity to present the following conversation with Father William J. Connolly, S.J., one of the founders and a staff member of the Center for Religious Development in Cambridge, Massachusetts. Perhaps a helpful way to introduce the interview, which took place in late January of this year in Cambridge, is to give our readers a chance to see how one of the programs in which the center is engaged is described in the 1979–1980 bulletin of the Weston School of Theology. We believe this program description could provide an illuminating bit of background for a more complete enjoyment and appreciation of Father Connolly's insights.*

About the Joint Program in Spiritual Direction

Our contemporary world manifests a developing interest in and desire for religious experience, prayer, and the spiritual life. Such interest challenges the Church to use its resources to train competent and effective guides to join with Christians and others who embark on their spiritual journey to God. Weston School of Theology and the Center for Religious Development have responded to this challenge by sponsoring the Joint Program in Spiritual Direction.

The Joint Program is based on a distinctive understanding of spiritual direction and a distinctive learning model. Spiritual direction is understood to involve three facets: the recognition that God communicates directly to his creatures; the appreciation that this communication is brought to awareness in contemplation and personal reflection; and the acknowledgment that the objectifying dialogue with a spiritual director is significant for the person. The model of learning employed in the Joint Program likewise has three dimensions: the actual practice of spiritual direction to provide experiential data; supervision of this learning experience; and theological reflection on the religious experience involved in spiritual direction.

The objectives of the Joint Program are to train men and women to practice this kind of spiritual direction, to learn how to profit from supervision, and to develop the habit of theological reflection; to have the graduates appreciate the crucial need for ongoing supervision in their ministry; to develop their ability to supervise others in this ministry at least at an elementary level; to enable the graduates to exercise leadership in the ministry of spiritual direction.

DIRECTION:

HD: Father Connolly, on the basis of your experience and teaching at your center, how would you define spiritual direction?
Connolly: In working with people in direction here, we begin with their own experience of God. Very often it's a positive experience, but it can also be a negative one. We initiate spiritual direction by exploring that experience and then asking something like, "Do you want to continue to experience Him in this way?" or, "Do you want to experience God in a different way?"

HD: So there would be two central elements you consider at the start of direction—the directee's experience and his or her desire. Is that right?
Connolly: That's correct. First, "I have experienced God. This is what He seems to be like; and this is the way I react." Or, it could be, "I don't know whether I've experienced Him." Then comes the second element, "I want something. I want to talk about my uncertainty as to whether I have experienced Him," or "I want to continue experiencing Him this way," or "I want this experience to develop," or "I don't like the experience I've had; I feel there must be something more."

HD: You repeatedly use the expression "experience God." What does that imply?
Connolly: A very broad range of experience. It implies that we know God with more than just reason. Reason concludes to the existence of God, or reason can accept the existence of God from the Church's witness. But there's also in a person a way of relating to God, a way in which his affective center—something besides his reason—relates to Him. That relating can range all the way from a simple perception and reaction when an eight-year-old child looks at a sunset and feels there is a Someone in the universe Who is awesome and Who is concerned with him—all the way from that to mystical marriage. Through that whole gamut of experience there is not only rational conclusion about God; there is also a reaction, an awareness of and a reaction to Him, that you could say is the heart's reaction, the feelings' reaction. You could call it some kind of emotional awareness and reaction. But it's more than reason. And it is this experience that we begin with in direction.

HD: It sounds, as you describe this experience, as if it could be a one-sided way of relating.
Connolly: It does go on in the religious person. He does the thinking about God, and he has the affective response to what he encounters in the outside world or in his own thoughts.

HD: Does God play any part in that experience?
Connolly: Yes, He does. He can communicate—to use Ignatian language—and wants to communicate directly with his creatures, at least sometimes and under some circumstances. In spiritual direction, the point of our beginning with the person's experience is that when God does communicate, it's liable to be through the person's experience. And so, the directee can begin with his experience of God without asking himself immediately, "Can I prove that *this* experience is God communicating with me?"

HD: Will he ask that question later?
Connolly: He will, and perhaps very soon. He may then spend a lot of time looking at ways in which he can see whether this really is God communicating with him. But he can't begin with that. He has to begin by looking at the experience. If he were to begin by asking himself immediately, "Can I prove this is God?", he would shut off the experience and never give it a chance.

HD: So the director helps him, from the very start, to focus on the experience itself.

Connolly: Yes. Helps him to focus on the experience and see what in the experience is calling to be looked at.

HD: How does the director do that?
Connolly: First of all by asking, "What is your experience of God?" Perhaps not in those words, because we're not accustomed to looking at our own "experience," to taking it so seriously that we really do believe that God may be communicating with us. So there may be a fair amount of discussion that would come before a person would really take his experience seriously enough to look at it and then ask himself, "Is this God?" The director's role would be, first of all, to help him to take his experience seriously enough to look at it, and not take it so seriously that he absolutizes it.

HD: What do you mean by "absolutize it"?
Connolly: Well, a person can make an experience of God *God.* He can make it so absolute that he can allow himself no other experience, for example, of God; so the director will help a person to see what the experience is saying to him about God and himself, but not so exclusively that he cannot leave himself open to any other experience—of the Church, for example.

HD: When you say the directee can make his experience "so absolute that he can't allow himself any other experience of God," are you talking about one that would change the way he perceives God?
Connolly: Yes. One that would, for example, develop the way he perceives Him.

HD: So it would be like any relationship; if one demands that the other person be constantly the same, one deprives oneself of any new way of perceiving or relating to that individual?
Connolly: Exactly. We can see God as awesome, and see Him as awesome in so absolute a sense that we can never see Him as loving.

HD: Can we go back to your way of defining spiritual direction?
Connolly: I'd like to do that. The reason I began to talk about spiritual direction by emphasizing experience is the fact that what we do in directing—look at the person's experience and let that develop—gives us our description of what spiritual direction is. Spiritual direction, if it centers on and respects a person's experience, is facilitative; it's not directive. The director himself depends upon the person's experience and attempts to facilitate the relationship with God that is recognized in that unique experience.

The director is going to be doing what any facilitator does, pointing the person toward God, as God may show Himself in the person's experience, or asking the person whether he wants to continue to pay attention to God as He shows Himself, or whether he would prefer not to—whether he'd rather see God in some other way. He will help the person to listen to God as He is showing Himself in his experience and to recognize when he is not listening. He could experience but not pay attention, for example. He will also help the person to give to God, if he chooses, more of his own feelings, his own emotions, his own reactions, and perhaps, more of his own response, as God shows Himself in his experience.

So facilitation will work in both directions, pointing toward the experience of God and saying, "Do you want to pay attention to that?" and also pointing to the person himself and saying, "Do you want to pay attention to your feelings? Do you want to pay attention with your heart? Are you seeing the experience in a relatively rational way, but not letting yourself *feel* what it means?"

HD: Can all that be summarized in a definition of spiritual direction?
Connolly: I can try. The definition I would give would depend upon the existence of experience and would go something like this: Spiritual direction is a pastoral task in which one Christian person helps another person to recognize God acting in his life and to determine what he wants to do about responding to that action.

HD: I have the impression that spiritual direction means different things to different people these days. Is the emphasis you are placing on experience something new, and perhaps different from what I might find in a center of spirituality other than your own?
Connolly: I can't, of course, speak for other centers. I can say this though: Many of the people who come here for direction, or who come here to work as directors on the staff, find that the emphasis on experience, making it focal, is new to them. They've usually heard of it. They've often used the term. But the emphasis that says direction really begins with experience, direction is facilitative of experience, and direction is secondary to experience—the living out of that emphasis is new to them.

HD: But compared with the practice of spiritual

The director depends upon the person's experience and attempts to facilitate the relationship with God that is recognized in that experience.

direction, which goes a long way back in the history of the Church, would you call this emphasis new?
Connolly: Much of the terminology is new. We would use words like "experience," "feeling," "reaction," that earlier ages of the Church would not have used. We would also emphasize perhaps in a finer way the modulations of emotional experience that a person might undergo. For example, if a person does experience God in a particular way and doesn't like what he experiences, I think because of the development of the study of the psyche, the director would have more patience, perhaps, and maybe more ability to help the person to stay with those modulations. In other words, we are able to help him accept the fact that he doesn't like the experience, and then to encourage him not to feel that his "not liking" is a repudiation of God. We can help him allow himself to say to God that he doesn't like it, and say what he feels about it, and to realize that this response itself can begin a communication between himself and the Lord. Then it can develop, and very favorably for him. We can do things like that, which directors in past times might well have done but without having a language to describe what they were doing.

HD: It sounds as if you are implying that your type of spiritual direction has come under the influence of contemporary psychology and counseling.
Connolly: Yes, I think we know, perhaps better than a spiritual director operating in France in 1830 would have known, some words that can be used to describe a person's encounter with God. We probably also understand the modifications of feeling that develop. We might be able to accept some of the person's feelings that come about in reaction to God better than an 1830 director would have.

HD: Why do you pick a director in 1830?
Connolly: Because that decade represents a very conservative time in the history of spirituality. Conservative attitudes toward prayer and toward the relationship a person has with God had been strongly emphasized and underlined by the Church's reaction to the French Revolution and its anticlerical aftermath. So 1830 would represent a period when spiritual directors would have tended to be quite conservative and would have believed in this conservatism.

HD: How do you think St. Ignatius would have reacted 400 years ago if he had been able to look ahead and see what your center is emphasizing in spiritual direction?
Connolly: That's a good question. Many of the ideas that we have about spiritual direction we've developed from Ignation texts. We've begun, I would say, with our own experience as directors, that is, with the experience of people who have come for direction over the years to the people on the staff. We have tried to listen to people's experiences of God and tried to help them to develop that experience if they wanted to. So perhaps our most basic principles come from that experience. But we've also gone to the Ignatian texts and in a way checked our experience against what Ignatius is talking about. I tend to use particularly Ignatius' *Autobiography*, which describes his own experience, and the text of the *Spiritual Exercises*, which is also drawn from his experience. It's a compilation of things he found useful in his own spiritual life, in his own spiritual development. The work that I do in direction could, I think, be described this way: It's an attempt at a dialectic between the experience of people whom I have known, or other staff members have known, and what Ignatius is saying about his experience, and what he's suggesting to other people.

HD: You've referred several times to your staff here at the center. What's its history?
Connolly: It began in 1971, and could not have begun earlier than that, I think, because Jesuits and other religious before 1971 were not in a position to recognize how central to renewal of the Church and of religious life are the things that go on in a person's experience of God, in the development of convictions about God and about his life. To a great extent, spiritual direction had fallen on arid times

before the 1970s. One of the best examples I can offer is that when I wanted to pursue studies in spirituality in 1968, a number of the Jesuits I talked to really felt that spirituality was a peripheral area of knowledge, that if you studied systematic theology or studied psychology, then you really had the grit of spirituality, and you could draw your own spiritual conclusions.

In 1971, a training program in the giving of personally directed retreats was given in the New England Province, a program organized under Father Dominic Maruca of the Maryland Province. It was sponsored by the Jesuit provincial, because the province itself had reorganized. It had tried to renew its government structures, its way of relating government to individual Jesuits, and then found that changing government alone was not enough for renewal. You didn't renew by simply doing that, because men's hearts and feelings and attitudes remained the way they had been before the structural changes. So with this in mind, the provincial suggested a program in personally directed retreats. About five of us who had had some experience in these retreats worked with Father Maruca, and about 15 Jesuits who were selected by the provincial participated in the program.

After the training program for directors was over, we all offered our services to the province, and 300 men made directed retreats in New England that summer. They weren't forced to; they were offered the directed retreat; they were told what it was, and they decided they wanted to make such retreats. The experience of having 20 men or so look at directed retreats together brought all 20 of us closer to the Ignatian sources; for one thing, it had us reread them, and then persuaded us that Ignatian spirituality could be a real help to people if we began by listening to people's experiences. So out of that whole experience of training to give directed retreats came the idea that it might be a service to the Church to found a permanent group of people who would listen to people's experiences and try to help them develop that. Out of that germ of an idea came the center. That program on directed retreats took place in 1970–1971, and the center was founded after the "300 summer."

HD: Are you saying that the Center for Religious Development was established as a place where people would be trained to give Ignatian retreats?
Connolly: No. We didn't see ourselves as basically retreat givers. That is, at least some of us who gave that program or made the program saw ourselves basically as people who listened to other people's

A person who lets God approach him only in terms of what he should or shouldn't do never comes to see God as God wants to be seen.

experiences of God, and then said to them, "Well, what do you think you might do now?" This can be done in a retreat setting. It can be done over a coffee table, or it can be done while having a drink. But basically we didn't see ourselves as first of all retreat givers, or first of all people who give spiritual direction, but rather people who could listen and who could find out what a person wanted. We also saw ourselves as people who had a real need to talk to other people who were doing the same thing. We felt that out of that listening and discussion could come something that we might or might not call spiritual direction, and that we would learn from the experience of others, which we would refine through our own discussion.

HD: And is that what is happening at the center today?
Connolly: I think it is. I think when we're doing things right, it is. We began by listening to people, and talking to them. During that first year, 1971–1972, there were no associates at the center. There were five or six staff members. As that year went on, we negotiated with Weston School of Theology to try to set up a program for people who had pastoral experience and wanted to develop themselves precisely as spiritual directors. Again, by spiritual directors, we meant people who were doing the sort of thing we were doing. Weston was willing to think in terms of seeing this as a graduate program and willing to grant a degree for it.

HD: Why was it essential for them to have had pastoral experience?
Connolly: Because what we ourselves try to do is

not work with a technique, and the people who come to work with us are not here to learn a technique. In order to put aside technique, or to see through techniques and work with another person's experience and relate to that experience myself, I need a good deal of life experience first of all, and I need experience of working with people on the basis of faith. So in some ways, a person who doesn't have life experience or pastoral experience has to fall back on techniques, because he has nothing else to fall back on. So we find that the more pastoral experience a person comes with, the better he's going to be at direction during the program year.

HD: Is there a certain kind of person who makes a better spiritual director?
Connolly: Are you asking about temperamental differences?

HD: Yes, I am. It sounds to me as if, when you're exploring a person's experience with him or her, you have to be, for example, an interested or curious kind of individual, with the ability to listen and communicate well.
Connolly: Well described. You would have to be genuinely interested in another person's experience, because it says something to you about God, because it says something to you about another person's relationship with God. Curious enough to say, "Gosh, that is fascinating, isn't it. Could you tell me more about it?" Curious in that way. Not a negative kind of curiosity, and I want to rule that out.

HD: You don't want a spiritual voyeur.
Connolly: (smiling) No. I'd just as soon avoid that if possible. But there is a kind of interest, of curiosity that tries to find out more about the way God acts and about the way people respond to Him, and I'd want to emphasize that. It's the relationship with God that a spiritual director gets interested in, then endlessly curious about. So he finds ways to ask questions about it that help the person to look at his experience. He finds ways of saying, "Gosh, you know, you're wondering what you can do, or you're wondering where that may lead, if you let it lead anywhere. What do you think? What possibilities do you see?" He is really interested in what the possibilities might be. Those qualities are essential.

HD: It doesn't sound as if the spiritual director, as you describe him, assumes a moralistic stance.
Connolly: That's right. By moralism, you would mean that all life gets reduced immediately to a division between what I should do and what I shouldn't do. We believe that the spiritual tradition of the Church and Scriptures, and the theology of the Church, too, invite us to look at what God is doing and to react to that. They tell us that moral life will spring from what we see, and our willingness to respond. We believe that is the case. So when a person will let God approach him only in terms of what the person should or shouldn't do, he never really comes to see God as God wants to be seen. He has to let himself—if he's going to look at God as God comes—contemplate first, before he begins to make moral decisions. Now, the distance from letting oneself see God as God is to making a moral decision might be a short one, but that distance has to be there. It might be a moment, but the person really has to recognize, if he's going to go on contemplating, that he first has to let himself see the Lord and enjoy Him, respond to Him. Then he can start deciding what he should or shouldn't do.

HD: Some of your associates, I know, are women. Do you find any difference in the way they practice spiritual direction compared with men?
Connolly: Well, we've always wanted the center staff, both the permanent members and the associates, to contain both men and women; we wanted men and women to work together. We've found through experience that that was a really sound hope. I personally would never want to work on a staff made up entirely of men. Men and women working together complement one another in spiritual direction and in the discussion of spiritual direction. As far as quality of direction is concerned, perhaps the best directors who have worked in Cambridge have been women. This is not to put the men down, because we've had some very good men directors, too. But perhaps the best have been women. The quality of direction given by women has often been superb. As I'm thinking of your question, I'm asking myself, does a woman director do direction in a different way from the way in which a male director does it? I'm sure she does, but I'd find it hard, really, to put words to the difference. Both have to listen; both have to react with more than their reason to what the directee is saying; both have to recognize an experience of God that is more than a rational experience; both have to treat the directee receptively and respectfully; both have to respond; when directors do these things, they are good directors.

HD: You said you would always want a mixture of

men and women on your staff because they complement one another. What are the characteristics you've seen to be complementary?
Connolly: Well, I think of one woman who brings a very great ability to listen to what people say behind the words that they speak, and so can hear a person's spiritual experience, probably more perceptively than I could. Whether if I developed my masculine sensitivity I could hear as well as she can with her feminine sensitivity I don't know. I know for a fact, though, that she does hear with extreme sensitivity, and she also has a very courageous way of letting people know what she hears, but it's a way that doesn't put them off. It's a way that enables them to look more closely at themselves. I guess, if I thought of male directors and staff members who have worked here, I wouldn't begin by describing them in quite that way. I think I might say that one man who worked here had a very strong grasp of what happens in the human personality when a person encounters another person, what occurs in relationships. He had been trained as a clinical psychologist, and he was very perceptive of what went on in people. I think he's a very sensitive man, too, and he wanted to hear people's experience and respond to it, and he did so very successfully. Now I'm aware that I'm speaking of the same area of competence, in speaking of the man and the woman, but I think I'm speaking about it differently.

HD: Is she a trained psychologist too?
Connolly: No, she isn't. I need a little more time to think about men and women directors in terms of complementarity.

HD: Then let me ask you about your hopes for the center. Thinking of the next five years, would you want to keep doing what the center is doing or move in some new direction?
Connolly: I think that as a center, we would want to do better what we're doing now; that is, we would want to help directors to be more sensitive to religious experience, more sensitive to what it can say, what it can mean. We would want to help them to be more and more fully facilitators, and this involves a change in the director himself. He himself has to become more sensitive to God and more sensitive to people. That would be our goal, to influence spiritual direction by working with them in a deeper way. But it is even more important that the direction work that we ourselves do, as a staff, becomes more perceptive, more respectful of people's experience, more and more willing to let people stand before God, and to see what happens there, and to ask them whether they want to continue to do that, more fearless in living with the consequences of their experience. The quality of our own direction comes first. I don't think we can help others become better directors unless we become better directors ourselves.

HD: Will you say a little about your programs?
Connolly: One is a program in which we bring people with pastoral experience here to work as associates with us. I'm choosing words carefully, because the associates are not students; they're not student directors. They're associates working on the staff. We choose them because they have had pastoral experience, and we give preference to people who already have done spiritual direction. We're careful about the titles, because we do not want to be giving student direction to the people who come to our center, and we believe that we're not. So we're avoiding the word student, or trainee, in speaking of associate staff members.

HD: But your associates are taking courses, are they not?
Connolly: Yes. They take some courses as a means of reflecting upon the experience of direction they're having.

HD: What is required?
Connolly: Nothing is required, I think, that someone who is not an associate here would be studying. In the past, before the program became fully formulated, associates took courses that students for the Masters in Divinity would take. That was found unsatisfactory, because their experience of direction did not then sufficiently determine what they studied. There wasn't a sufficiently close connection between the experience of direction that they were having and the course content. So now, an associate staff member will be reflecting on his experience by making use, say, of the *Spiritual Exercises,* and by reflecting on them from the point of view of Ignatius' experience, and his own experience as a director. He'll approach the spiritual theology of Karl Rahner from the point of view of a person who is working with people's experience of God. He'll approach the history of spirituality from the point of view of a person who is himself heavily engaged in the religious experience of other people. These courses are all designed for people who are having experience in direction. So in a way they're not purely academic courses at all. Someone who, say, was interested in the history of spirituality, I

There's an endless variety of ways in which spiritual direction can be helpful. It could be one half-hour conversation in a lifetime.

think, would not choose a course that might be called the "History of Spirituality" here, but is actually designed for the benefit of people who are engaged in this particular experience. The associates take up a course here because they want to reflect on their experience. They don't take a course for the sake of taking a course.

HD: Do you provide close supervision for their direction work?
Connolly: Yes. They come in order to talk about themselves as directors with someone else who has had experience in direction. That desire is the basis for supervision. Each permanent staff member will work with a number of associate staff members over the year, and what the supervisor is interested in is the associate as director, how he's developing as a director. We focus on his ability to listen to another person's spiritual experience, his ability to avoid telling another person what he thinks he should be doing, his ability to hear carefully and reflect to the other person what he's hearing, and his ability to hear *anything* from the directee.

HD: Are there other programs you offer?
Connolly: There are. We have a program for people who are in early formation in religious communities. Men and women from different religious groups come here for a program that is designed to help them consider and develop their own prayer, and the means that might be useful for them in developing their prayer, for example, the possibility of individual spiritual direction. We also do a number of programs in New England for diocesan priests and religious who are themselves interested in giving spiritual direction. We've done a number of programs, and continue to do so, on the development of a new spirituality in the renewed Church, on a spirituality that takes account particularly of the relationship between spiritual life and affective life.

HD: Do you work with the laity or just with priests and religious women and men?
Connolly: We do work with lay people. You notice that most of these programs were ministerial: they're for ministers. We do a lot of spiritual direction with lay people, an increasing amount of spiritual direction with them. Perhaps, and this would be a guess, half the people who come to the center right now for direction are lay people.

HD: And how many associates are directing them?
Connolly: There is a full staff of 16 people now, four permanent staff members and 12 associates. But in our ministerial programs we are encountering more and more lay people interested in giving spiritual direction themselves.

HD: Are more of the laity seeking spiritual direction here from year to year?
Connolly: More lay people, yes. I think in the last four years or so, the number of lay people asking for direction has increased each year, and quite markedly. And more non-Catholics have been asking for direction. During this past year, for example, approximately half the people who began direction are not Catholic. It may be an even higher percentage.

HD: Would you say that everyone who is serious about pursuing religious life or a spiritual life should have a spiritual director?
Connolly: No. I wouldn't. I'd rather approach it from this point of view: If a person is serious about the development of his relationship with God, then he'll look for means that will help him. The means might be giving himself some time, for example; giving himself an opportunity to talk to people who can suggest suitable reading for him; he might want to attend a course in Scripture. Among these means, I would say spiritual direction should be considered as one possible way to help a person.

HD: Could it be short-term direction?
Connolly: It could be very short term. There's an endless variety of ways in which spiritual direction can be helpful. It could be one half-hour conversation in a lifetime. For example, the rich young man

When a person decides on spiritual direction, a great deal depends on how much is going on in his spiritual life at the time.

got some spiritual direction from Jesus. The desert monk might have got spiritual direction in five minutes from another desert monk. When a person decides on spiritual direction, a great deal depends on how much is going on in his spiritual life, that is, whether it's plateaued and seems quite satisfactory to him, or whether it can be seen best as jagged, so that he's up and down. It might be an excellent spiritual life, by the way, because it *is* jagged. Depending on how much shift and change is occurring, a person will find it more or less useful to talk to another person. So I generally will say, "Think more carefully about spiritual life, if there's a lot of movement going on in your spiritual life, in your relationship with God, and in relationships with other people that your relationship with God may be leading you to."

HD: One final question. To meet the desires of people who will want spiritual direction, would you say that the Church will probably need the establishment of many centers such as this one in the future?

Connolly: I think that in a Church where spiritual life will be seen as depending less on structure, on the fact that there is a bishop, that there is a parish priest at the rectory, that the Sacraments are administered, and there's a sermon given at every liturgy—in a Church that sees the spiritual life as dependent indeed on the structure, but needs more for its growth than the structure, I think that people who perform the kind of function we perform are going to be necessary. How we're going to come by them, I can't say. The people who have worked with us on the staff seem to feel that they are better able to help other people than they would have been if they hadn't worked on the staff, and many people refer others to people who are on the staff now or who have worked on it. That, I think, is about all that I could say: that when people look for help with spiritual life in this area, they very often have us pointed out to them, or people who have worked with us.

HD: I want to thank you for myself, and on behalf of our readers.

This is the first of a two-part article.
Part II, "Coping with Stress in the 1980s," will appear in the summer issue.

THE STRESSES OF LEADERSHIP

Psychobiologic Costs That Need Not Be Paid

Hardly a newspaper, television program schedule, magazine, or institutional bulletin board appears these days without some reference to stress, a book on stress-management, a stress clinic, or a stress-reduction workshop. The topic is mind-grabbing, appealing in some way to nearly everyone. And why shouldn't it be so in a world of missile-rattling superpowers, economic recession, monetary inflation, fuel shortages, Third World poverty, famine, terrorism, street crime, and marital disasters?

Arnold A. Mitchell of the Stanford Research Institute has observed: "Stress is a major problem in the contemporary United States. It negatively affects the daily lives of scores of millions of Americans. It causes a bewildering array of physiological, psychological, and social malfunctions. On an economic level, the effects of stress probably cost the nation over $100 billion annually. Moreover, available evidence suggests that stress-related maladies are on the rise."

Dr. Leon Warshaw, currently Deputy Director of the Mayor's Office of Operations of the City of New York, has termed Mitchell's view, which might at first seem somewhat exaggerated, a "gross understatement." He reminds us that there is no one

living anywhere whose life is not affected continually by stress. It causes illness and accidents; and even those who care about and must care for the victims are stressed. "It affects personalities, modifying our perceptions, feelings, attitudes, and behavior. And it reaches beyond its immediate victims to affect the political, social, and work organizations whose activities they direct and carry out. And these organizations, as living, functional entities, are also affected by stress: their growth and survival are very much related to their success in coping with stress," Warshaw explains.

Furthermore, it should be asserted that the whole world is filled with individuals under stress; collectively, their distress has impact upon the lives of all others within their societies, which in turn adds stress to the existence of people everywhere on our planet. But whence comes healing?

Those in leadership roles, particularly in the Church and its religious congregations, are naturally in a position to observe the kinds of stress their people are experiencing at work, in their communities, and in their personal lives. The apostolic outcome of leaders' efforts, combined with those of their followers, depends in large measure upon the success they achieve in recognizing, appraising, and controlling the forces that introduce crippling stress into their enterprise. The vitality and viability of their endeavors are continually at stake, and stress is an enemy quite capable of bringing even the "best laid plans" to failure, even disaster.

The whole world is filled with individuals under stress; collectively, their distress affects the lives of all others within their societies.

THE CONCEPT OF STRESS

But as every warrior knows, in order to fight an enemy successfully, you need to understand him. So what are we talking about when we speak of stress? We need some terms and concepts if we are to come to grips with this formidable, ubiquitous foe. Unfortunately, the word "stress" has come to be used in vague and sloppy fashion during recent years, perhaps because, as Cornell University specialist in occupational health Alan McLean has pointed out, the vast literature on the subject "stems from many and diverse disciplines, primarily psychiatry, clinical and social psychology, cultural anthropology, and occupational and internal medicine, with significant contributions from such widely different fields as behavioral toxicology and personnel management." Each of these disciplines is concerned with what are generally termed "psychosocial stresses," but communication across these disciplinary lines is notoriously poor. If you read works in these various fields, you will often find the same term used with different meaning, depending upon who is writing and the field in which he specializes.

Despite this confusion, we still have to rely on authoritative sources for our terminology. Perhaps a brief look at the history of the concept of stress might prove helpful.

Pioneer researcher and Nobel Prize winner Hans Selye, who first published his findings on the physiologic effects of stress in *Nature*, July 4, 1936, borrowed the term stress from the vocabulary of engineers and physicists. Scientists in these fields had long been using it to convey the notion of "enough force being applied to an object or system to distort or deform it." Were we to adhere closely to this original meaning of the word, we would be prompted to consider psychologic, personal, and emotional stress as stemming from forces operating on a person from somewhere in the surrounding environment and affecting him in ways that result in tension, strain, and even illness. But Selye's way of conceptualizing stress was quite different. He saw it as existing in the individual's body as a specific set of biological conditions that occur when an event or situation has an impact on the person and requires an adaptation of some sort.

DISTRESS VS EUSTRESS

Stress, according to Selye, is a nonspecific response of the body to any type of demand made upon it. Calling it "nonspecific" is simply to say that the response pattern is always biochemically the same regardless of the nature of the stressor. Bacteria, virus, heat, cold, physical injury, an interior emotional conflict, or a threat perceived as

arising in one's exterior milieu—all would stimulate or provoke identically the same kind of physiologic response. In Selye's own words: "From the point of view of its stress-producing or stressor activity, it is immaterial whether the agent or situation we face is pleasant or unpleasant. . . . It is difficult to see how such essentially different things as cold, heat, drugs, hormones, sorrow and joy could provoke an identical biochemical reaction in the body. Nevertheless, this is the case."

Recognizing that in human life not all stressful experiences are unpleasant or destructive, Selye selected additional terms to distinguish between a stress that is positive in its life consequences and one that is negative. He called the former eustress, the latter distress. Eustress is stress experienced by a person who is winning; there comes with it a sense of achievement, triumph, and exhilaration. A person who is losing knows distress. Disappointment, helplessness, desperation, insecurity, or inadequacy produce stress of the distress type.

STRESSOR, STRESS REACTION, STRESS

Dr. Richard Lazarus is another major contributor to the field of research into stress and ways of coping with it. He, too, locates stress inside the person rather than in the environment. However, he emphasizes the important role played by cognition (i.e., thought, or perception) in the individual's stress response. Lazarus regards situations or events themselves as being neutral; they only become stressful when perceived or appraised negatively. Thus, for a stress response to occur, a person must become aware of an exterior or interior situation or demand that calls into question his ability to cope with it successfully and painlessly. Psychologists Robert Woolfolk and Frank Richardson, authors of the useful new book *Stress, Sanity and Survival,* have adopted Lazarus' understanding of the nature of stress. They define it as "a perception of threat or expectation of future discomfort that arouses, alerts, or otherwise activates the organism."

In light of the formulations proposed by the behavioral scientists we have already considered, and for the sake of clarity and simplicity in our present discussion of stress, it would seem advisable to adopt the following three definitions: (1) The *stressor* is an event, situation, or condition that, perceived cognitively, produces a psychologic and biologic (or psychobiologic) reaction in the individual that is usually, but not necessarily, unpleasant and sometimes produces symptoms of physical or emotional illness. (2) The *stress reaction* is the response produced by the perceived stressor. It is often unhealthy (i.e., threatening to the person's total well-being), and includes affective (feeling, emotion, mood) as well as physiologic (especially hormonal) components. (3) *Stress* is simply the interior process that includes the stressor (event) as perceived, the stress reaction (response to the event), and whatever steps intervene between them.

Let's look at an uncomplicated example: A man who is waving a revolver suddenly throws open the office door and, with rage unmistakably driving him, moves menacingly toward the bishop who is seated at his desk. The stressor? An enraged man brandishing a lethal weapon at close range. The stress reaction? Presumably fear experienced by the bishop. This includes the psychic experience of that specific, unpleasant emotion, as well as the physiologic changes that accompany it (e.g., adrenaline secreted, increased heart rate, elevated blood pressure, stepped-up blood-cell production). And stress? The whole process, from perceiving the threat through feeling afraid and being physiologically prepared for "fight or flight."

CHANGE, MOVEMENT, AND STRESS

But what about leadership? And how does stress relate to it? In some special way? One could reply by stating bluntly: Stress is related to leadership in an inevitable way. Moreover, since leaders, by the very nature of their task, are attempting to influence others to strive willingly toward the achievement of the group's goals, stress will likely arise in the leader as well as the individual members whenever a conflict develops in regard to needs, expectations, or goals. The very concept of leader implies guiding, conducting, directing, and preceding—one who facilitates progress and inspires the group to accomplish organizational goals. But all this means insistence on movement, which is inseparable from change. And in whatever direction change (even development or improvement) moves, stress will soon be there to accompany it.

It would be impossible, even if this article were encyclopedic in scope, to cite all the ways stress can occur as a result of the ordinary interactions between leaders (superiors, formation teams, pastors, etc.) and those whose lives and behavior they are trying to influence. Consider for a moment the typical manner in which a stress reaction occurs: A person in a given situation perceives something

happening that constitutes a threat to his well being (recall our example of the bishop confronted by the man with the gun). A painful emotional response (e.g., fear, anger) accompanied by a flooding of hormones and steroids (e.g., adrenaline and cortisol) into blood vessels, organs, and tissues is automatic. Stating it more simply, all that is required to trigger a stress response deep down inside is perception of some form of personal loss. So, for example, when a leader with authority calls on his followers to travel a road that demands sacrifice or to give up a familiar way of doing things, loss is perceived as imminent: hormones and emotions take over. If the leader should encounter resistance, and his goal remains unaccomplished, the loss of power he senses may itself become a threat to his sense of worth, and now he in turn feels stress. More emotion (anger? resentment? grief?), and hormones at high tide!

SIGNS OF STRESS IN OURSELVES

Granting the fact that at times a bit of anger, anxiety, or some other distressful emotion is bound to occur in everyone's life, why are people becoming increasingly concerned about stress? Why all the current articles, books, and workshops focused on coping with it? Because in the past few decades, research scientists and medical practitioners have become convinced and are at last widely publicizing the fact that stressors affecting us in ways that are even moderately intense but prolonged and repeated are causing illness and bringing on death in alarming proportions.

People are beginning to understand that such afflictions as peptic ulcers, ulcerative colitis, high blood pressure, coronary artery disease, strokes, arthritis, hyperthyroidism, sexual impotence, bronchial asthma, as well as a broad range of psychiatric disorders, can be considered "preventable," because they are associated with stress that could be avoided or at least diminished. Still, a million deaths are occurring in the U.S. each year as a result of heart attacks and strokes alone. This fact reveals that the growing public awareness of the stress-relatedness of such events has not yet resulted in wide enough recognition of early warning signs and in taking appropriate measures to avoid illness.

Some of the danger signs that different individuals may detect in themselves as evidence of their being under stress have been pinpointed by Selye. It is important to remember that those signs and symptoms are highly personalized; that is, caused by malfunctioning of whatever organ or system of the body is—in a particular individual—most vulnerable. In other words, because of a hereditary or a life-generated predisposition, under comparable stressful circumstances one person will develop a headache, another a backache; a third will feel dizzy. Each of us could benefit by reflecting on Selye's list in order to learn to recognize which danger signs are being manifest in times of stress in our own lives. He includes: (1) general irritability, hyperexcitation or depression; (2) pounding of the heart (an indication of high blood pressure); (3) dryness of the throat and mouth; (4) impulsive behavior, emotional instability; (5) the overpowering urge to cry or to run and hide; (6) inability to concentrate, flight of thoughts, and general disorientation; (7) predilection to become fatigued, and the loss of *joie de vivre;* (8) "free-floating anxiety" (i.e., we are afraid, although we do not know precisely what it is we are fearing); (9) emotional tension and alertness, feeling of being "keyed up"; (10) trembling, nervous tic (i.e., brief recurrent, irresistible movement of a small segment of the body); (11) tendency to be easily startled by sounds that are not loud; (12) high pitched, nervous laughter; (13) stuttering and other speech difficulties; (14) gnashing or grinding of the teeth; (15) insomnia; (16) hyperirritability; (17) sweating; (18) the frequent need to urinate; (19) diarrhea, indigestion, queasiness in the stomach, and sometimes even vomiting; (20) migraine headaches; (21) premenstrual tension or missed menstrual cycles; (22) pain in the neck or lower back; (23) loss of appetite or compulsive eating; (24) increased smoking; (25) increased use of legally prescribed drugs, such as tranquilizers or amphetamines; (26) alcohol and drug addiction; (27) nightmares; (28) neurotic behavior, (29) psychoses; and (30) a marked proneness to accidents.

SIGNS OF STRESS IN OTHERS

Many people are inclined to overlook the signs of stress that appear in their own lives. But those who are serious about reducing the risk of becoming ill often find it helpful to ask a spouse or good friend whether he or she is noticing any of these danger signals in them. Frequently, too, a leader will note that distress in the lives of his followers will manifest itself in the form of (1) absenteeism (avoidance of contact with the stressful situation); (2) poor work performance (slipping obviously below the person's ordinary level of competence); and (3) excessive use of defense mechanisms (such as denial,

Stressors, affecting us in ways even moderately intense but prolonged and repeated, are causing illness and death in alarming proportions.

rationalization, or projection, which unconsciously enable one to fail to recognize, explain away or find in someone else the flaws in one's self). Depression, experienced as a chronic sense of dejection over one's total situation in life, is another sign of stress. (The various types and manifestations of depression are comprehensively presented in another article in this issue.) Anxiety is a further symptom of stress. It is perceived in oneself as a pervasive sense of apprehension, dread, and "uptightness" that develops when one anticipates danger, the source of which is largely unknown or unrecognized, and feels he does not have effective plans for dealing with this threat.

PHYSICAL AND MENTAL SIGNS

Increased alcohol consumption is another sign. People under stress are naturally in search of relief from the physical discomfort that exists in a body made tense by painful emotion. Alcohol provides this longed-for realization, but at a price. Far from taking away the cause of the stress, it is merely a palliative. Frequently, mounting pressures encountered at work or at home tend to invite more and more drinking, and it is this increase in intake that signals—often first to others—that stress is beginning to "get to" a person. Stepped-up coffee drinking, reliance upon sleeping pills, aspirin, and even laxatives can signal the same message.

Author Jack Tressider, in his popular book *Feel Younger, Live Longer,* offers helpful checklists that separate the mental from the physical signs of stress. He has observed that those who are manifesting three or more of the following physical signs may be placing their bodies under high risk from excessive stress: (1) excess weight for your age and height; (2) high blood pressure; (3) lack of appetite; (4) desire to eat as soon as a problem arises; (5) frequent heartburn; (6) chronic diarrhea or constipation; (7) inability to sleep; (8) feeling of constant fatigue; (9) frequent headaches; (10) need for aspirin or some other medication daily; (11) muscle spasms; (12) feeling of fullness although you have not eaten; (13) shortness of breath; (14) tendency toward fainting or nausea; (15) inability to cry or a tendency to burst into tears easily; (16) persistent sexual problems (frigidity, impotence, fear); and (17) excessive nervous energy that prevents sitting still and relaxing.

Having five or more from the following list of mental symptoms (or four from the two lists combined) suggests the same high risk condition: (1) a constant feeling of uneasiness; (2) constant irritability with family and work associates; (3) boredom with life; (4) a recurrent feeling of being unable to cope with life; (5) anxiety about money; (6) morbid fear of disease, especially cancer and heart disease; (7) fear of death—your own and others'; (8) a sense of suppressed anger; (9) an inability to have a good laugh; (10) a feeling of being rejected by your family or community; (11) a sense of despair at being unsuccessful as parent, teacher, leader, etc.; (12) dread as the weekend approaches; (13) reluctance to take a vacation; (14) a feeling you can't discuss your problems with anyone; (15) an inability to concentrate for any length of time or to finish one job before beginning another one; (16) an uncontrollable terror of heights, enclosed spaces, thunderstorms, or earthquakes.

Those in positions of leadership who detect in themselves or in their followers a sufficient number of these red flags to suggest that they may be walking a path to disease should certainly not panic or despair. The appropriate response is one of seeking out the sources of the stress and then devising a suitable remedy.

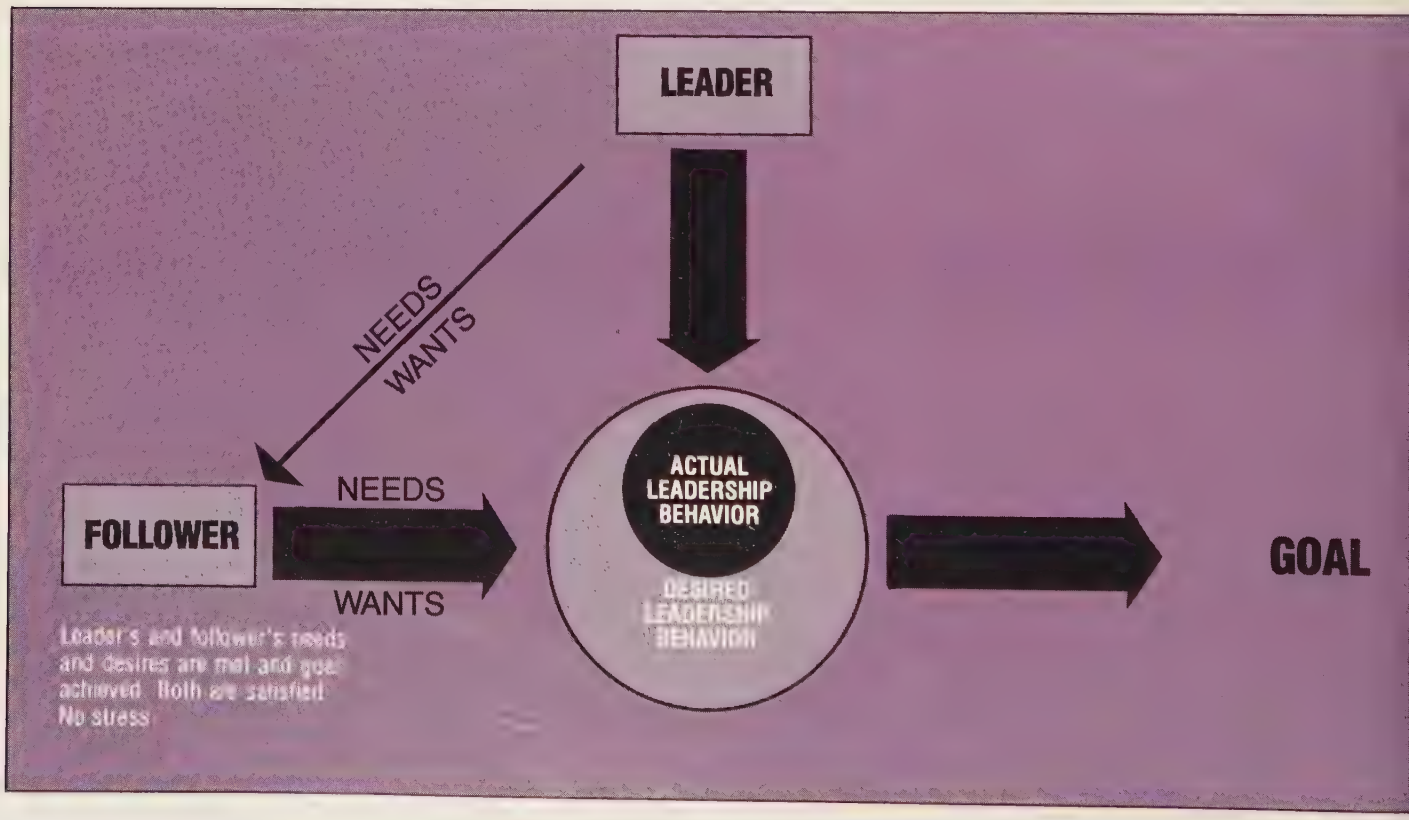
LEADER-FOLLOWER RELATIONSHIPS

What might be called the classical sources of stress arising from the leader-follower relationship would seem to provide a logical starting point for one who is looking for the origins of distress in any given situation. Both leader and follower may want to achieve the same fundamental goal, but a clash is likely to occur if the preferences of these two with regard to the means to that end are contrary to each other. For example, on one hand the leader may be, by nature, a task-oriented person who feels

When the leader does not provide what is needed or what the follower feels entitled to, both are destined to suffer stress.

that Christ's desire for His Church is accomplished by leader and followers devoting themselves unstintingly and incessantly to accomplishing worthwhile endeavors ("good works"). A follower, on the other hand, desiring to fulfill the same ultimate aim, may personally need and desire a leisurely social atmosphere in which to function, a climate for *agape*. He will find that the leader's efforts to keep his followers constantly active at doing things will prevent the establishment of close relationships and shared affection. Under conditions such as these, it is virtually inevitable that both leader and follower will wind up feeling frustrated, the former because he will sense that his follower is resisting his leadership, the latter because this fundamental need remains unfulfilled. Obviously, if both leader and follower preferred the same goal and at the same time needed and desired the same means to that end, no stress (at least from this source) would occur.

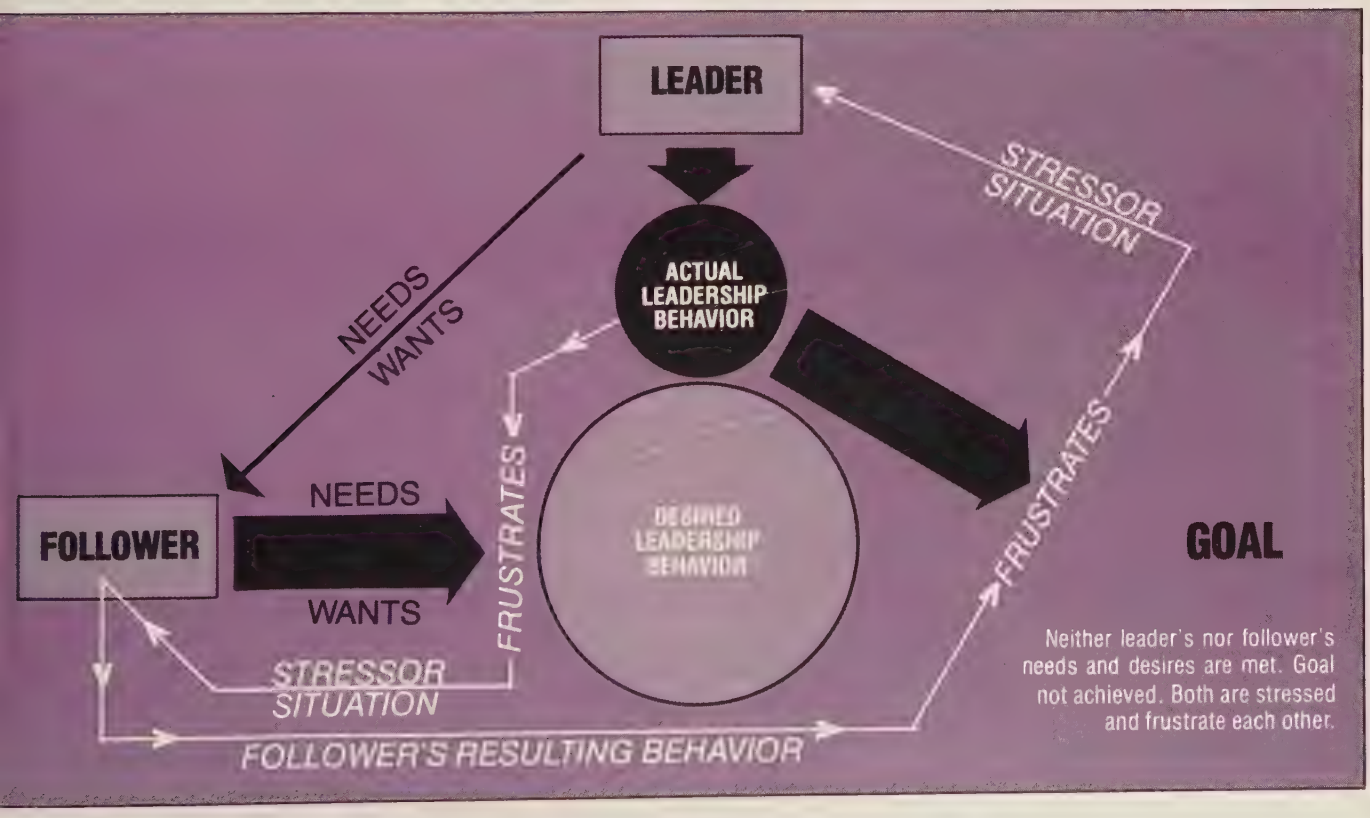
Another classic example would arise from the style of leadership adopted. When both leader and follower naturally prefer and the leader adopts an autocratic approach (one in which the leader commands and expects compliance, is dogmatic and positive, and leads by the ability to withhold or give rewards and punishment), mutual satisfaction ensues. But suppose that the follower has an intense need and desire for a leader whose style would be democratic (the leader consults with subordinates on proposed actions and decisions and encourages participation from them). In this case,



again, when the leader does not provide what is needed or what the follower feels entitled to, both the follower and the leader are destined to suffer stress, since frustration of the desire of both is now occurring.

What is the nature of the stress that is experienced by leader and follower in such situations? It can take various specific forms, depending upon the personalities involved. First of all, frustration (experienced whenever fulfillment of one's needs, wishes, desires, or plans is prevented) automatically produces anger, one of the unpleasant and painful emotions. Not uncommonly we find people who are angry handling their frustration by blaming someone other than themselves for their inability to achieve the fulfillment of their desires and needs. They become hostile and tend to lash out at those they are blaming. So the leader may turn hostile, as may his follower. But not necessarily. Some people, when their wishes are frustrated, become angry and blame themselves for their lack of success in achieving their aims. They become depressed and often experience feelings of guilt or shame as well.

Complicating the examples we are considering could be unconscious elements, since nobody ever has simply one need at a time, and we are never consciously aware of all our needs or wishes. In fact, by the process of denial, which was mentioned earlier, we may even inadvertently blind ourselves to what is really happening in our own emotional lives. In the example where the follower is not deriving from his leader's behavior the kind of help he wants, he becomes frustrated and angry. Still, he may not be able consciously to accept as real either his anger or the hostility he feels toward the leader. Why not? Because he may also have such a strong and constant need to please and win the approval of any authority figure in his life (starting with parents), that he dare not disclose, even to himself, the fact that he is harboring these strong negative feelings. So, deep down inside he is in conflict. Part of himself is motivating him to show hostile resentment; another part is prompting him to act as if he were content, appreciative, and supportive of this leader. Such conflict inevitably generates the type of tension and anxiety we considered as evidence of stress. And this can occur in the leader too. All he need do is pretend to himself, as well as to his follower, that his heart is full of unalloyed love and



gratitude, when in fact he is also feeling resentment because of the opposition he senses, and he too will experience the tension that comes from being in ambivalent inner conflict. A little more stress enters the scene.

We could go on citing examples. Some people are stressed when they hear criticism, from below as well as from above. Some are so impatient that any delay in executing their plans produces immediate anger, if not rage. Some are so perfectionistic that even the slightest flaw in performance (their own or another's) becomes intolerable to them. Others are so competitive that not even for a moment can they relax and escape the anxious tension that they feel. Stress can and does arise in countless ways in group situations when leadership is involved. But that doesn't mean that all the painful signs and symptoms, the stress-related illnesses, and the premature fatalities mentioned earlier must necessarily occur.

There are means that leaders and followers can employ to cope with the kinds of interpersonal situation likely to produce stress. These can at least diminish, if not completely eliminate, the self-destructive consequences. Some can be presented in the form of insights derived from behavioral sciences and from practical clinical experience with people who have sought professional help to find better ways to deal with the stressors in their lives. Other methods can be presented in the form of specific techniques that can be learned and put into practice with the same goal in mind.

There are means that leaders and followers can employ to cope with the kinds of interpersonal situations likely to produce stress.

HOW TO COPE WITH STRESS

Let's begin to establish a more effective coping repertory by examining a series of insights outlined by Dr. Jere Yates of Pepperdine University in his recent book, *Managing Stress.* (His suggestions are italicized.)

1. *Build and maintain an adequate sense of self-esteem.* People with a decreased sense of personal worth are more likely to become anxious and hostile when they perceive they are being treated negatively in interpersonal relationships. Self-esteem develops when we feel loved and are able to show love in return, especially in devoted service to others or to a worthy cause.

2. *Establish "stability zones"* (areas of your life in which little or no change is taking place or is occurring at a relatively slower pace than in other parts of your life). This helps reduce the amount of stress you must cope with when life tends to become filled with turbulent change. Religion, close family and community ties, customs, traditions, and routines help to provide an increased sense of stability and security.

3. *Develop effectiveness and efficiency in employing your competencies.* People who are uncertain of their skills and other abilities are more inclined to feel stress when they are called upon to perform. Continuing education and performance-monitoring or "supervision" (by consultants, directors, friends, etc.) can facilitate life long development.

4. *Strengthen your professional qualifications.* People only weakly qualified are more vulnerable to suffering from stress. Think of a teacher with poor credentials or degrees when the time comes for reduction of faculty size. People with strong qualifications experience less stress when crisis comes because they have more options available to them.

5. *Learn cognitive strategies.* Most important among the factors determining your reaction to a stressor is the way you perceive or think about it. Managing your thoughts is an effective means of reducing stress. For example, think about the fact that the stress you are experiencing will not last forever. Or that what is a fact is a fact, and there's no use arguing about it. Talk to yourself in times of stress. Decide in advance what words you are going to say to yourself in moments of pressure. (Example: When the leader starts finding fault with me, I'll tell myself, "Don't argue, listen to him; you might learn something useful.") Rehearse again and again what you plan to say. Replace the "self talk" statements that don't work for you successfully by holding down your stress.

6. *Take sufficient vacations.* Uninterrupted long-

term encounter with stressors creates distress. Our body tissues and organs need intermittent relief from constant bombardment by stress-related hormones and other biochemicals that will otherwise eventually produce illness. A break is not long enough if one does not return to action feeling rejuvenated as well as relaxed.

7. *Live lovingly.* The person who is manifesting and receiving such qualities as warmth, kindness, caring, and cherishing is experiencing a healing of the wounds that distress may have caused. When Jesus prescribed that His weary disciples should "come apart and rest," it was to be "with Me." I am quite certain this provision was essential; they were in need of experiencing His presence as healing, stress-reducing Love.

8. *Clarify your personal values and live according to them.* Behavior that is at cross-purposes with your ideals cannot help but increase your stress level. You may not be consciously aware of this impact, but given enough time, it will eventually take its toll. Books on "values clarification" are often helpful to a religious person sincerely desiring to eliminate personal stress arising from this source. So is the annual retreat, which affords opportunity to rearrange the activities of one's life so that they are in harmony with one's real values.

9. *Monitor your own life's pace.* Stress comes from attempting to do too much, always striving to please others and never oneself, and from neglecting to live a balanced life. Time is needed for physical exercise and play, as well as rewarding work; for soul-satisfying prayer and other spiritual exercises; for gratifying intellectual pursuits, and for heart-expanding cultural experiences of beauty. Our need for novelty and for creative accomplishments is too easily overlooked in religious people's busy and altruistic lives. If we are positioned through God's Providence to serve others by helping them learn to discover the full richness and goodness of life, surely in conscience we ought first to learn how to develop our own total humanity and love of life, with God's help, so that belief, reliance, and learning can become possible for others when we offer ourselves as their leaders or helpers.

EIGHT RECOMMENDATIONS

To end the first half of this article on stress and ways of coping with it, especially in leadership situations where *influence* is deliberately involved, it might be useful for us to list eight brief recommendations Selye has made after a lifetime of research and practical experience. Yates has provided this paraphrasing of these guidelines from the master:

1. Don't waste your time trying to befriend those who don't want to be recipients of your love and friendship.

2. Don't be a perfectionist; strive to do something that is within your capabilities.

3. Don't underestimate the genuine pleasure that can come from the simple things of life.

4. Carefully assess each situation to see whether a syntoxic (tolerate it) or catatoxic (engage it in battle) response will serve you best. Only fight for that which is really worth it.

5. Concentrate on the pleasant side of life and on the activities which can improve your lot. As the old proverb says, "Imitate the sundial's ways; count only the pleasant hours."

6. When you do experience a setback or defeat, reestablish your self-confidence by remembering all your past accomplishments.

7. Don't procrastinate in tackling the unpleasant yet necessary tasks you have to do. Get them over with quickly.

8. Realize that people are unequal in many ways at birth. All people should have access to equal opportunities, and their progress should be evaluated on the basis of their performance. Leaders are leaders only as long as they have the respect and loyalty of their followers.

In March 1977, *U.S. News & World Report* sent a journalist to interview Selye. The last question the writer asked him was: "If you had to give one piece of advice to people about stress, what would you say to them?" His reply was straightforward: "I would offer the wisdom of the Bible translated into terms a scientist can easily accept today: Earn thy neighbor's love."

RECOMMENDED READING

Selye, Hans. *Stress Without Distress.* New York: Signet, 1974.

Woolfolk, Robert, and Richardson, Frank. *Stress, Sanity and Survival.* New York: Monarch, 1978.

Yates, Jere. *Managing Stress.* New York: AMACOM, 1979.

Zaleznik, Abraham. *Human Dilemmas of Leadership.* New York and London: Harper and Row, 1966.

A 1980

Its various forms, its signs and symptons

We often hear and read in the U.S. these days about the shifting moods of our country's citizens. During the weeks following the Iranian militants' taking Americans as hostages in our embassy in Teheran, anger and impatience on a virtually nationwide scale replaced the moderate level of anxiety that, in the fall of 1979, stemmed from anticipation of an economic recession accompanied by inflation and widespread unemployment. But when the Soviet Union ordered tanks and troops to intervene in neighboring Afghanistan, the mood of our people underwent gradual transformation once again. This time, fear of military—perhaps even nuclear—confrontation between the U.S. and the U.S.S.R. rose abruptly.

People's reactions to this last alarming event seemed to demonstrate just how individualized emotional responses to one and the same situation can be. One man who owned considerable stock in a corporation certain to be awarded new government contracts for military hardware may have been overjoyed at his good fortune, while a woman university student, anticipating registration for a new military draft, would have begun to feel anxious about whether national mobilization would soon interrupt her education and postpone the attainment of her long-sought academic degree. Still others, like a 60-year-old retired Army officer, whose most exciting years of life were those of World War II and the conflict in Korea, conceivably were now in a state of exhilaration over the prospect of new battles and victories, as daily news bulletins flooded in via radio and TV from Afghanistan, Pakistan, Iran, China, Yugoslavia, Moscow, U.N. headquarters, and Washington, D.C.

What seemed striking in these instances was the way the various feelings different individuals were experiencing served as motivation for markedly different kinds of behavior on their part. The same world situations and events, perceived in highly personalized ways by these separate citizens, provoked strikingly dissimilar affective states (joy, fear, excitement) that, in turn, stimulated three distinct types of activity in response. The stockholder repeatedly contacted his broker, instructing him each time to increase his investment at once. The draft-threatened student began conversations with U.S. Navy representatives about enlisting in her

LOOK AT DEPRESSION

nd who does what about them

university's reserve officers training program so that she could complete her education even if national mobilization should actually occur. The old soldier, at the very same time, went out and purchased a new TV with wider screen, elated that news programs were now at last presenting events that absorbed his interest and provided grist for new but nostalgic conversations about battlefields, firepower, planes downed, wounds, and body counts.

THE DEPRESSIVE SPECTRUM

With all this in mind, it would seem quite apparent that anyone who is concerned about helping others to live their lives according to fundamental principles or values, as religious persons do (whether Christian, Jewish, Muslim, or otherwise), should be just as aware of the emotions, moods, and feelings those people are experiencing as they are of the ideals or convictions they espouse. These affective states, we must realistically concede, will always be providing much of the motivation for their behavior. Thus, for example, if you are endeavoring to help a religious sister improve her prayer life or her effectiveness in dealing with the persons she contacts in the course of her ministry, it would seem to be of paramount importance to pay careful attention to whether her predominant mood is habitually one of hopefulness, apathy, fear, anger, or despondence. And since anyone's affective state (mood, feeling, emotion, or passion) will be influencing what that person thinks about, what absorbs his imagination, what he undertakes to do (or avoid doing), to what extent he accomplishes the goal he pursues, and the quality of impact he has on the thoughts and actions of others, it would seem obviously expedient to help every religious person to learn all that he can about his own affective life and its implications in relation to community, prayer, and personal development, as well as ministry.

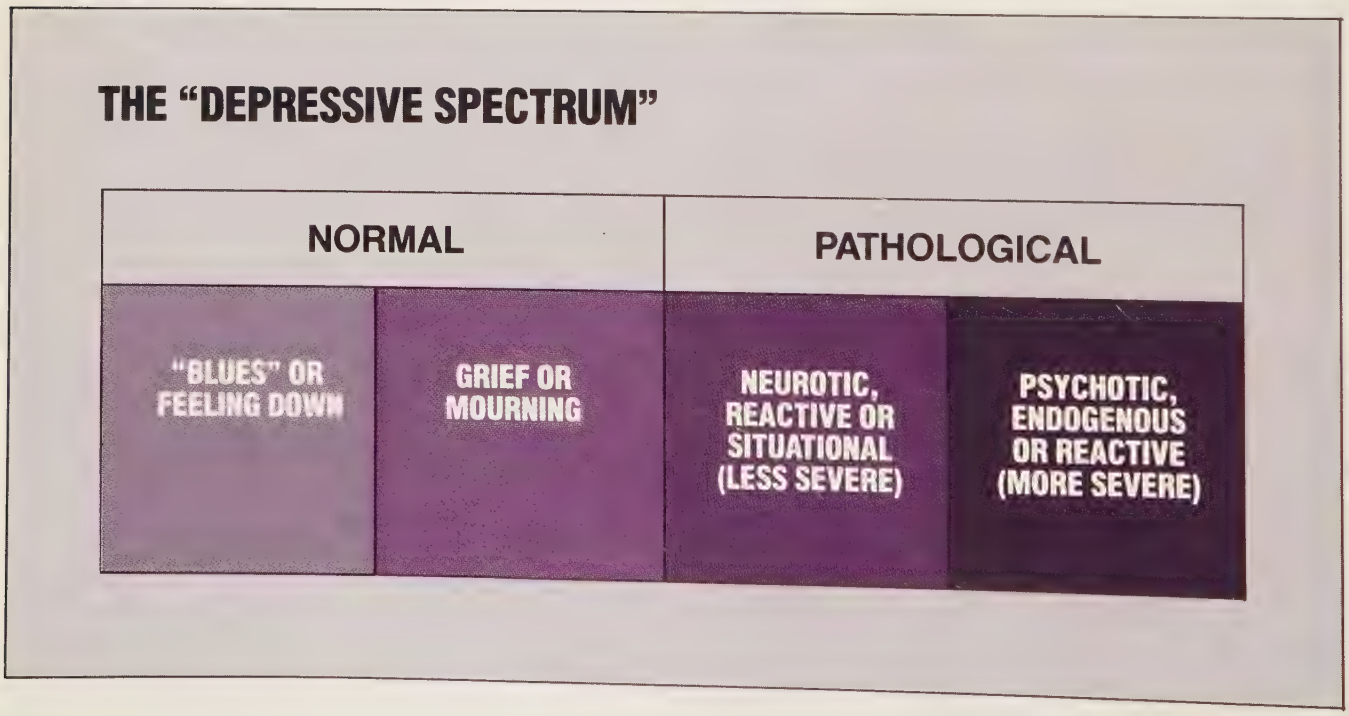
There will be many opportunities within future pages of *Human Development* to examine diverse spiritual and pastoral aspects of the variegated affects we all—as human beings and as religious persons—continually experience. But, as a starting point, there would seem to be wisdom in our

exploring in this initial article an emotional state that gives rise to sometimes enormous and at other times subtle and disguised problems in the lives of religious persons. That affect is depression. The term is used in psychiatry to characterize broadly the affective human condition that, on a worldwide scale, stands out clearly as the most prevalent of all the kinds of emotional distress, one that both men and women, be they lay or religious, occasionally experience—and some chronically.

It is depression that sometimes drives formerly affable and gregarious persons into a state of sad withdrawal from people and from ministerial involvement. It causes in some an inability to face God in prayer. It prompts still others to abandon their vocations, and occasionally carries someone to the extreme point of suicide. At times, religious superiors and other Church leaders see depression convert contented individuals into cynics. Spiritual directors all too often find depression being confused with spiritual desolation by their directees. Formation personnel observe that frequently a person's depressed state, especially in the novitiate or seminary, stands as a roadblock in the way of his or her spiritual and social growth. These are just a few of the countless ways in which depression alters human and religious behavior. Many surprisingly diverse signs and symptoms are providing evidence these days of its frequent presence in our communities, perhaps even in our own lives.

Depression sometimes drives formerly affable and gregarious persons into a sad state of withdrawal from people and from ministerial involvement.

But it is time to stop speaking as if depression were a single, monolithic, psychologic entity. It is not. Contemporary clinical research and laboratory studies have demonstrated convincingly that we should at this point in history be thinking in terms of a "depressive spectrum" that includes a number of somewhat similar (but also significantly differ-



ing) affective states, not all of them by any means pathologic.

The National Association of Mental Health has defined depression as "an emotional state of dejection and sadness, ranging from mild discouragement and downheartedness to feelings of utter hopelessness and despair." It is this range of affective responses that Georgetown University psychiatrist Dean Schuyler sees constituting the depressive spectrum. Within it he includes several "depressions which can be termed normal as well as those which are generally regarded as clinical, that is, deserving of professional treatment." At the normal end of the spectrum, one experiences what the ordinary person would be likely to describe as "feeling blue," "down," "unhappy," or simply "under the weather." At the other extreme—where psychopathology is unmistakably evident—one finds the psychotic depressive state, which manifests itself as an inability to function normally. It is sometimes accompanied by hallucinations (sensory perceptions not founded on objective reality) and delusions (beliefs proceeding from a false premise that cannot be corrected by reason).

NORMAL SADNESS

The "blues" are considered normal feelings, just as anger or fright would be, since we all feel somewhat sad or apathetic at times. On those occasions, when our thoughts are repeatedly drifting toward some form of disappointment we are experiencing, we don't feel much like eating, our sleep is less restful, and we find being with others less enjoyable. The blues usually last only a few hours or at most a few days. Some people even feel them on holidays or anniversaries or after the birth of a child. (Expecting intense joy sets the stage for disappointment.) The blues generally pass without anyone around us noticing our mood, since we can carry out our work and other ordinary activities without disruption.

THE MOURNING TASK

Also at the normal, or healthy, end of the depressive spectrum is the so-called grief reaction, which occurs when we lose someone important to us through death. If we were not to feel to some extent depressed under such circumstances, our mental health would surely be questionable. Dr. Erich Lindemann accomplished a classic study of the grieving process among the bereaved survivors of the Coconut Grove nightclub fire in Boston. The characteristics he consistently noted included physical distress (sighing, tightness in the throat, empty feeling in the abdomen, and lack of muscle power), preoccupation with the image of the deceased, guilt, hostile reactions, and loss of usual patterns of conduct. Feelings of loneliness, helplessness, anger, and relief are all generally experienced at some time during the several months required to accomplish the "work" of mourning.

NEUROTIC REACTIVE ILLNESS

Grieving or mourning, then, is normal. But at times this healthy type of condition is pathologically transformed into what Freud identified as a "depressive reaction" usually classified technically as "neurotic." Grief has progressed to this state, he observed, when the mourner's focus shifts from the lost person to a preoccupation with his own inadequacies. Both mourning and neurotic depression, Freud recognized, involve (1) painful dejection, (2) withdrawal of interest, (3) inhibition of activity, and (4) loss of capacity to love. The neurotic (or reactive) depression additionally involves (1) decreased self-esteem, (2) self-accusation, and (3) need for self-punishment.

Schuyler has pointed out that reactive (neurotic) depressions, which follow a so-called precipitating event, are also associated with losses other than those sustained through death. Disruption of friendship, job loss, or financial setback can provide such an occasion just as readily as can separations (moving, starting or graduating from school, divorce) and taking on new responsibilities (new home, mortgage, or job). You cannot be certain that any specific event will precipitate a depressive reaction in any given individual's life. Some people are more likely than others to become depressed. Their vulnerability appears to be related to experiences undergone during their childhood years as well as to their unique genetic inheritance.

The term "neurotic" is sometimes used loosely to denote the severity of the pathology found associated with a specific case of depression. Physicians use the term, as do psychologists and other counselors, to designate a given instance as less severe. "Psychotic depression" is the label they reserve for the more severely imparing kind of illness.

PSYCHOTIC DEPRESSION

At the extreme, pathologic end of the depressive spectrum is this psychotic type of depression. Striking among the characteristics of this kind of

emotional illness, which is sometimes, but not by any means always, precipitated by an external event, are the physical symptoms (called vegetative), which are only rarely present or prominent in neurotic depression. These include sleep, eating, and bowel disorders, together with significant weight change. But what identifies the psychotic condition most precisely is the afflicted person's loss of ability to evaluate objectively and make accurate judgments regarding the world outside the self. This loss is technically called an impairment of reality testing. It is most apparent in the instances when depressed persons experience hallucinations and delusions, which were mentioned and defined earlier.

A psychotic depression is sometimes found to be endogenous, as distinguished from the reactive type. The former presents no precipitating event, and physical (somatic, vegetative) symptoms are usually prominent. Endogenous signifies "arising from within." Illness that develops in this fashion is generally considered to be biological (genetic, metabolic, or biochemical) in origin. One of the forms of psychotic depression thought to be genetically determined is the bipolar type, which involves episodes of mania along with episodes of depression. The manic phase of bipolar illness is characterized by heightened excitability, acceleration of thought, speech, and bodily motion, by elation or grandiosity of mood, and the presence of emotional irritability.

SIGNALS OF DEPRESSION

What are the other signs and symptoms that a person in a role involving spiritual, religious, or ecclesiastical leading, guiding, forming, counseling or directing should learn to recognize and understand as related to depression that is clinical (i.e., deserves professional treatment)? Recently, a professional publication for physicians pointed out that "the central characteristic of these depressive disorders is a marked loss of interest in all usually pleasurable outlets such as food, sex, work, friends, hobbies, and entertainment. This inability to derive pleasure from life is pervasive." But to be more specific, the changes you may observe in someone depressed at any point across the spectrum will fall into the following four categories: emotional, physical, cognitive, and behavioral. To appreciate these changes in an individual, it is essential to compare that person's present mode of feeling or functioning with that which he or she has previously habitually manifested, as well as the accepted norm for his or her age, sex, and social group.

Schuyler has provided the following list of changes likely to be seen in depressed persons. (1) Emotional changes: (a) sadness, (b) anxiety, (c) guilt, (d) anger, (e) mood variation during the day; (2) Physical (*somatic*) changes: (a) sleep disorder, (b) eating disorder, (c) constipation, (d) menstrual irregularities, (e) weight loss, (f) weakness, (g) easy (or constant) fatigability, (h) pain, (i) diminished sexual drive; (3) Cognitive changes: (a) negative self-concept, (b) negative view of the world, (c) negative expectations for the future, (d) self-blame, (e) self-criticism, (f) indecisiveness, (g) helplessness, (h) hopelessness, (i) worthlessness, (j) delusions; (4) Behavioral changes: (a) crying, (b) withdrawal, (c) retardation, (d) agitation, (e) hallucinations.

The signs or symptoms just mentioned may be encountered as evidence of depression existing at any point from blues to psychosis on the spectrum we have been considering. A few comments on some of the items on this list might be helpful. As mentioned earlier, the principal symptom of depression is loss of ability to enjoy the things in life that previously brought pleasure. Even in its milder forms, depression often turns food tasteless, sex unexciting, work and hobbies boring and unfulfilling. Close friendships may seem empty and cold.

- Sadness, although typical of depression, is not always felt as a symptom. Different depressed individuals report different predominant emotions: confusion, worry, inability to feel any strong emotion, demoralization, guilt, hopelessness, self-doubt, self-blame, and irritability (i.e., very easily upset emotionally).
- You will find it very difficult to make a depressed person laugh.
- Depressed people often speak in a very low voice, answer questions very slowly, and perform ordinary physical tasks far more slowly than usual. The term "retardation," used alone, suggests all of these phenomena.
- The agitation at times demonstrated by rather severely depressed persons is recognized in loud, rapid, and sometimes incessant speech, often punctuated with complaints and requests for help. Hand-wringing, pacing, cuticle picking, or hair pulling are among the frequently observed signs of agitated depression.
- Change in sleep pattern is a common sign of depression. Increased sleeping, lethargy, and waves of fatigue are noted, but not as often as insomnia, which may include difficulty in falling asleep, fre-

A 1973 survey in the U.S. suggested that in any given year, 15% of adults between 18 and 74 may suffer serious depressive symptoms.

quent awakenings throughout the night, and early-morning awakening.

- Depressed people sometimes report feeling better as the day progresses, after feeling "terrible" in the morning. Some reverse this pattern.
- Vague complaints of headache, backache, abdominal pain, and constipation, without apparent cause, often accompany depression. Hypochondriacs are frequently persons who are suffering from neurotic-level depression. They complain excessively about physical symptoms.
- Alcoholism is often either cause or effect of depression.
- Altered academic or spiritual performance is as symptomatic of depression as change in work satisfaction or achievement.
- Severe endogenous depressions are far more likely than less severe ones to lead to serious suicide attempts and not abate with time or with psychotherapy alone.
- Job advancement, as well as loss of job, can result in depression. So can accomplishments of long-term goals (e.g., being awarded an academic degree).

FREQUENCY OF DEPRESSION

What are the chances of your encountering signs of depression in someone within your range of ministerial care or your community? A few statistics might shed some helpful light. Harvard University psychiatrist Ned Cassem, writing in 1979 on depression, has reported that this "commonest among psychiatric disorders"—if you count only the cases sufficiently severe to warrant professional care—"affects from two percent to four percent of the general population. Although this condition ranks first among reasons for psychiatric hospitalization (23.3% of the total hospitalizations), it has been estimated that 92% of all persons suffering from it are treated by nonpsychiatric personnel or are not treated at all." A 1973 survey conducted in the U.S. suggested that in any given year, 15% of adults between 18 and 74 years may suffer serious depressive symptoms. This amounts to about 20 million adults in this country alone.

WHO HELPS AND HOW?

Early recognition of depression will generally make possible early treatment and relief, if treatment is indeed required. But let's look at the full depressive spectrum briefly once again and try to answer the question: Who does what for the depressed person?

BLUES

At the blues end of the spectrum, where nearly every person finds himself occasionally, helping the person experiencing the depressive symptoms generally amounts to encouraging him to remember that these usually pass within hours or a few days, and that engaging in some gratifying form of activity (despite one's apathy and wish to withdraw) may effectively dispel the depressed mood (e.g., conversing with a friend, jogging, listening to music, dancing). Psychotherapy is not needed and medication would be inappropriate.

GRIEF

Dealing helpfully with a person undergoing a grief reaction usually amounts to assisting him in breaking the emotional bonds with the lost person, adjusting to life without the deceased, and forming new relationships. Affective elements with which he can be helped to deal include loneliness due to the actual departure of the loved one, helplessness because the loss is irreversible, anger arising from feeling deserted, and sometimes relief related to negative feelings or burdens associated with the deceased. Only rarely is it necessary for such help to be provided by a professional counselor. Friends, relatives, and close members of his community can generally help the bereaved person to cope successfully with his grief.

Even though grief is painful, it does not ordinarily require active medical intervention. Emotion-dulling medications should certainly be avoided,

but a mild sedative to aid sleep is occasionally advisable. It does the mourning person no good at all to be protected in any way from facing the facts of death, separation, and loss. Preventing the "grief work," as outlined above, from being properly and completely accomplished may result in prolonging the symptoms or in the resurfacing of depressive symptoms at some future time.

Professional counseling for the person undergoing a grief reaction is generally needed under only two circumstances: when the bereaved is without any close family member or friend to provide emotional support, and when the process has persisted for more than several months and the pervasive grieving has shifted its focus from the deceased to the self, with symptoms increasing in number, intensity, or both, showing that the person's depressive state has passed from one of mourning to a reactive depression.

It is, of course, a paradox that the most disabling types of depressive illness are the most effectively treated of all.

SITUATIONAL DEPRESSION

An individual who is undergoing a reactive (neurotic or situational) type of depression in response to either an internal conflict or an identifiable external event will usually require psychotherapy or counseling. Antidepressant drug therapy and electroconvulsive shock therapy are rarely useful in this less severe form of clinical depression. Such patients are not ordinarily hospitalized. Antianxiety medications and mild sedatives to aid sleep are sometimes recommended.

Psychotherapy with these persons aims at effecting termination of the depressive episode and also encourages enough personality alteration to decrease the probability of subsequent episodes. The patient is helped to reorganize his thinking into new constellations that do not bring about sadness and to reorient him to see the possibility of different optional choices with promising new consequences in his life.

This milder (neurotic) form of illness, which represents about 75% of the incidence of clinical depression, is usually treated in one of six ways: (1) psychoanalytically oriented psychotherapy, (2) cognitive therapy, (3) behavior therapy, (4) interpersonal psychotherapy, (5) group therapy, and (6) marital therapy.

PSYCHOANALYTIC TREATMENT

The classical psychoanalytic understanding is that clinical depression involves a psychological regression to infantile levels of thinking, feeling, and behaving. This regression is precipitated by the patient's guilt and aggression resulting from his difficulties in relinquishing his emotional ties to a lost object. The loss may be actual, but more frequently noted is a situational change that affects the person deeply as a significant loss. Hostility and guilt feelings accompany an internal struggle between his ego and superego. Treatment aims at bringing this conflict into conscious awareness through the therapist's interpretation of resistances, dreams, free association of ideas, and the working through of the transference (i.e., the unconscious transfer onto the therapist of feelings and attitudes that were originally associated with important persons in the patient's early life).

COGNITIVE THERAPY

Cognitive therapy, developed by Dr. Aaron Beck, is based on the assumption that the way a person structures his experiences by his thinking will determine the quality of his affective responses, including depression. The technique deals specifically with the patient's problems of low self-esteem, misperceptions, tendency to blame himself unduly, and his underestimation of his abilities. Beck sees as the therapist's task: (1) identifying major maladaptive patterns of thinking that give rise to the patient's depressive symptoms; (2) focusing on what Ellis terms the "automatic thoughts," which are depression-generating cognitions; (3) increasing the patient's objectivity toward these cognitions (distancing); (4) neutralizing the depressive cognitions and helping the patient to recognize their maladaptive consequences; and (5)

weighing and considering alternative explanations. Case examples illustrating this mode of treatment can be found in Beck's 1967 book, *Depression: Clinical, Experimental and Theoretical Aspects.*

BEHAVIOR THERAPY

Behavior therapy, as a theory, explains depression in terms of stimulus and response: inadequate positive reinforcement from the environment elicits the various aspects of the depressive state. The patient's own negative behavior may bring about this deficiency. A number of techniques are aimed at helping a person overcome his behavioral inadequacies. These include social-skills therapy (emphasizing training in assertiveness, verbal ability, and social judgment); training to increase pleasurable and rewarding experiences; training in self-control with an emphasis on self-monitoring, evaluation, and reinforcement; encouraging affective expression and time projection (i.e., orienting the patient to the future).

INTERPERSONAL THERAPY

Interpersonal therapy is founded on the assumption that depression develops in a social and interpersonal context and is determined by the interpersonal interactions between the patient and significant persons in his life. This type of treatment does not attempt any deep alteration of personality. It focuses on the patient's symptoms and social adjustment and has as its goal the improvement of the quality of his social adjustment. This is accomplished by enhancing his ability to cope with stress, restoring his morale, and helping him deal with the personal and social consequences of his disorder. The central therapeutic issue is the way the patient is functioning "here and now" in his interpersonal relationships.

GROUP AND MARITAL THERAPIES

In group therapy, a trained clinician and a group of patients attempt together to effect change in the depressed emotional state and attitudes of the patients by using the participants to provide feedback to facilitate change. Marital therapy focuses on altering the interaction between marital partners and is based on the assumption that depressive symptoms can be reduced by accomplishing such change. There is no convincing evidence that either of these treatment strategies is more effective than any of the several mentioned above, nor is any of the others more effective in treating depressed persons than these.

It is well established that the effectiveness of each of these six modes of treatment can often be enhanced by the use of antidepressant medications. The effects are additive, since these drugs reduce the vegetative symptoms (such as sleep and appetite disturbances) while psychotherapy improves the patient's ability to relate interpersonally.

TREATING SEVERE DEPRESSION

Persons at the severe end of the spectrum who develop endogenous depression are treated by physicians, usually as outpatients, and antidepressant medications are prescribed. Nearly 80% of those who receive these so-called tricyclic drugs (thus termed because of their chemical structure) experience relief from their symptoms within one month. Sleep and appetite return to normal within one week. Improvement in affect may not be evident for two to four weeks. Six to eight months of maintenance therapy with tricyclic antidepressants will probably be required after an acute depressive episode in order to prevent relapse. This form of medication is most beneficial in the case of a patient suffering from unipolar depression (i.e., episodes of depression without episodes of mania) who also has vegetative symptoms (e.g., loss of appetite, weight loss, insomnia). For patients with bipolar depression, lithium carbonate is generally prescribed to bring about a reduction of both the depressive and the manic tendencies.

It is, of course, a paradox that this most disabling type of depressive illness (including the manic-depressive form, recurrent psychotic depression, and depressive illness with a preponderance of endogenous symptoms) is the most effectively treated of all. It includes about 25% of all cases of clinical depression. Along with antidepressant medication, hospitalization and electroshock therapy may be required.

PSYCHOTHERAPY

Whenever psychotherapy is skillfully added to antidepressant therapy in treatment of depressed patients, the results are significantly improved. Schuyler has written that this supportive verbal (psychotherapy) treatment should involve the following: (1) explanation relating the patient's physical symptoms to depression; (2) assurance that the patient's illness is self-limiting and that he or she will get well; (3) explanation of the patient's

illness to the family (or religious community) and enlistment of their aid in managing the patient; (4) acceptance of the patient despite his or her rejection of the therapist; (5) encouragement of direct methods of self-expression of the patient's feelings; (6) emphasizing to the patient that he or she should not embark on any major psychologic or social changes during the course of the illness; (7) fostering in the patient understanding, hope, and appropriate planning for the near future; (8) protection of the patient by anticipation of the risk of suicide; and (9) providing the patient with a well-structured daily program, if necessary.

Any exploratory psychotherapy aimed at uncovering the unconscious elements of the patient's problem is usually reserved for the periods between his episodes of depression, should his depression be recurrent. This between-episodes intervention may take the form of psychoanalytic, cognitive, or behaviorally oriented psychotherapy. The goal will be to prevent or lessen the severity of future depressive episodes by changing the patient's attitude, feelings, behaviors, or psychologic style.

"A realistic approach to treating high-risk patients requires that the therapist be emotionally . . . prepared to lose the patient to suicide."

HOSPITALIZATION

At some point in the course of a severe depression, the question of hospitalizing the person may arise. The decision should be made by a physician. Factors to be considered will include the risk of suicide, pathologic interaction with the patient's family or members of his community, need for electroshock therapy, and difficulty in establishing an effective relationship with his therapist. There is today in the U.S. a decreasing tendency to hospitalize patients with psychiatric illness. Early recognition of symptoms and prompt treatment with medication (prescribed by a physician) as well as psychotherapy (often under the care of a nonphysician) can be given much of the credit for this accomplishment. Still, there may be some benefit in recommending hospitalization for the depressed person even when his condition is not extremely severe and no significant risk of suicide is apparent. This might be done whenever a pathologically ambivalent (hostile but clingingly dependent) relationship has developed between the patient and some member(s) of his family or religious community. A relationship of this nature may serve to prolong the illness. Consequently, removal from the environment for at least several weeks is often advisable.

Hospitals, whether general or psychiatric, provide a controlled and protective atmosphere that frequently contributes a great deal to the resolution of the depression. It is not at all unusual for a patient to begin to show marked improvement promptly after being admitted to a hospital. This reduction in the depression's severity provides both patient and physician a better chance of building together an effective, collaborative, therapeutic relationship—one that can speed up the recovery process considerably.

ELECTROCONVULSIVE THERAPY

If, however, the combination of antidepressant medication and psychotherapy fails to achieve relief from severe depression, the patient's doctor may decide to initiate a course of electroshock treatments, which will usually begin in a hospital but will often be continued on an outpatient basis. Researchers have found that such therapy achieves improvement for an additional 10% to 15% of depressed patients who did not respond to treatment with antidepressants. Electroshock (frequently referred to as ECT, for electroconvulsive therapy) is prescribed with remarkable success for patients who are severely depressed and acutely suicidal. Its effectiveness, current research suggests, is possibly due to a change in cerebral protein synthesis or to the release of increased quantities of norepinephrine (a hormone the brain requires for nerve-impulse transmission initiated by the ECT treatments). As many as 100,000 Americans a year may be currently undergoing this form of therapy, often with amazingly quick recovery. Dr. Lothar Kalinowski, who has administered ECT at St. Vincent's Hospital in New York City for 40 years, has said: "Electroconvulsive therapy is far superior to antidepressant drugs because it can get someone

well in a week or two, especially in cases of suicidal depression."

Dr. Fred Frankel of the Beth Israel Hospital in Boston has acknowledged that ECT is "not a panacea," but "it is a very useful treatment that has not been improved upon for some cases of depressive illness, particularly when the patient is too depressed to take food or fluids."

SUICIDE

Suicide is always a possibility when a person experiences depression as severely painful. Physicians will generally hospitalize those patients who seem to be at high risk in this regard. Such action is usually taken in an effort to protect the patient from self-harm when (1) the patient is unsure that the suicidal impulses can be resisted; (2) a suicide attempt has just been made; (3) the risk is seen to be high, the patient is not well known to the therapist, and a supportive relationship has not been established with anyone else available to the patient; or (4) the suicidal state is related to an organic brain syndrome, such as alcohol withdrawal or the effect of a psychedelic drug (e.g., LSD).

Schuyler, who provided this list of conditions, has also repeatedly alluded to a fact that is all too familiar to psychiatrists and other professionals who deal with people considering suicide: You cannot—even in a closely supervised ward in a psychiatric hospital—always prevent a patient from succeeding in taking his own life. Dr. Jerome Motto has frankly observed: "A realistic approach to treating high-risk patients requires that the therapist be emotionally and progressionally prepared to lose the patient to suicide. This implies an acceptance of his own limitations as well as a certain fortitude without which a psychotherapeutic effort is seriously handicapped." His is another way of saying that no one, not even a professional, can realistically expect to come out a winner every time.

DISEASES, DRUGS, AND DEPRESSION

A final point that might be helpful for religious persons dealing with apparently depressed individuals (whether lay or religious) to keep in mind is one not widely appreciated by nonmedical people. A number of neurological diseases (e.g., multiple sclerosis), endocrine disorders (e.g., hypothyroidism), malignancies (e.g., cancer of the pancreas), some viral infections (e.g., hepatitis, infectious mononucleosis), as well as some forms of heart and blood disease, often present symptoms characteristic of depression. Consequently, it is highly advisable that any person who remains feeling depressed for as long as a month without an external event having precipitated his distress should consult his physician so that a careful medical examination can be performed. And, just in passing, it should also be remembered that many of the medications doctors prescribe for infection, high blood pressure, heart disease, insomnia, contraception, gynecological problems, and certain kinds of connective tissue disorders will frequently leave those taking them feeling depressed. In such a case, it will usually be easy to inquire and discover that there is a clear association between the appearance of the depressive symptoms and the time when the medication was first administered.

It is hoped that what has been presented in this article about the signs and symptoms of depression, its various forms, and the ways in which treatment is professionally provided will be useful to the religious person who will from time to time be in a position to recognize the depressed condition of someone in his or her care and, when appropriate, refer that individual for medical, psychiatric, or psychologic assistance. Obviously, not every individual who is feeling somewhat depressed requires professional help. The variety of approaches to depression described here has been explained in some detail so that religious "helping" persons will have a relatively clear idea of what professionals try to do for the depressed and what measures nonprofessionals may be able to contribute by their intelligent and warmhearted support. Love, after all, is demonstrated in most God-like fashion when one knows how to show it in effective ways.

RECOMMENDED READING

Beck, Aaron. *The Diagnosis and Management of Depression.* Philadelphia: University of Pennsylvania Press, 1973.

Beck, Aaron, and Brady, John. *The History of Depression.* New York: Insight Communications, 1977.

Crammer, Leonard. *Up from Depression.* New York: Pocket Books, 1969.

DeRosis, Helen, and Pellegrino, Victoria. *The Book of Hope: How Women Can Overcome Depression.* New York: Macmillan, 1976.

Mendels, Joseph. *Concepts of Depression.* New York: John Wiley and Sons, 1970.

Schuyler, Dean. *The Depressive Spectrum.* New York: Jason Aronson, 1974.

APOSTOLIC HEALTH

Better Fitness for Ministry Through Exercise

Health Coach Dyveke Spino, co-founder of the Esalen Sports Center in California, recently complained: "We live in a society that equates *not being sick enough to go to a doctor* with being healthy. We go to a doctor when there is a symptom so serious that we can't handle it ourselves. The doctor treats that symptom and usually helps us get rid of it. We don't see him again until there is another such symptom or until we have a periodic medical checkup . . . But unfortunately his O.K. doesn't signify that we are in optimal health."

Spino recognizes that in our contemporary world, thanks less to members of our medical community than to specialists in other disciplines such as nutrition, biochemistry, physics, and research in endurance training, a new concept of health is emerging. In her recent book, *New Age Training for Fitness and Health,* she personally defines it as, "not merely the *absence* of disease" but also "the presence of adequate endurance, flexibility, strength, and mental powers to fully participate in and enjoy life." However, help is needed to attain that kind of health. Hence, the creation of a new type of professional—the health coach. And what does such a person do? In Spino's words, the health coach "helps individuals take responsibility for their health and instructs them in laying the necessary physical and mental base."

Her view sounds close to that of one of holistic medicine's most articulate spokesmen, Dr. Kenneth Pelletier of the University of California School of Medicine, San Francisco. Pelletier believes, as does the Institute for the Study of Humanistic Medicine in San Francisco, that "a person is more than his body. Every human being is a holistic, interdependent relationship of body, emotions, mind, and spirit. The clinical process which causes the patient to consult the medical profession is best understood as this whole and dynamic relationship. The maintenance of continual health depends on harmony of this whole." In *Holistic Medicine: From Stress to Optimal Health,* Pelletier, again like Spino, affirms that a truly holistic orientation would necessarily aim at educating the responsible patient.

The span of holistic medicine, thinks Pelletier, is far broader than current medicine's preponderantly surgical and pharmaceutical approach, since this new model includes "prevention, life-style modification, psychological counseling and supporting the patient as a responsible individual . . . Giving patients information about diet, exercise and life-style modification helps them overcome disorders produced by daily activity, habits, and stress." According to this new concept, medicine (which has focused traditionally on diagnosis, prescription and treatment of pathology) would be regarded simply as *one aspect* of comprehensive health care.

It was while recently reflecting on these ideas that I happened to be reading some parts of the *Constitutions of the Society of Jesus.* Written during the decade before his death in 1556 by the Society's founder, Ignatius of Loyola, the book is the saint's legacy to his Jesuit sons, a set of guidelines to help them give the greatest possible glory to God. It directs them to live and work in such a way that they can effectively participate, as vowed volunteers, in the accomplishment of Christ's redemptive plan for all people of all time. The book is a collection of statutes and ordinances providing specifications for structures of government, choice of ministers, selection of recruits, and even life-style.

What struck me particularly was the chapter on

"The Preservation of the Body," in which Ignatius writes: "Just as an excessive preoccupation over the needs of the body is blameworthy, so too a proper concern about the preservation of one's health and bodily strength for the divine service is praiseworthy, and all should exercise it. Just as it is unwise to assign so much physical labor that the spirit should be oppressed and the body be harmed, so too some *bodily* exercise to help both the body and spirit is ordinarily expedient for all, even for those who must apply themselves to mental labors."

Sounding as holistic as any avant garde practitioner of medicine today, Ignatius even prescribed: "For an hour or two after taking a meal, especially during the summer, strenuous exertions of the body or mind ought not to be permitted. . . But other light activities may be pursued during this time. Even outside these hours it is not good to continue to work for a long time without some relaxation or proper recreation."

I found myself wondering how the saint had acquired such strong and precise convictions about what would be beneficial and what would be harmful to his followers. Fortunately, the answer was within reach. Father George Ganss, S.J., who translated and published an English version of the *Constitutions,* took the trouble to add a footnote that proved to be, at least for me, strikingly enlightening. He writes: "Ignatius' concern to preserve the health and bodily welfare of his subjects flows as a corollary from his esteem for natural gifts. His experience increased this concern. Mannaerts (1523–1614) relates (in his *Exhortations, II*) that a few years after the foundation of the Society, when Ignatius observed that many, shortly after their entrance, were wasting away and dying, he called a meeting of physicians. When they learned of the austere life many were leading, they marveled that the number of those who had died was not greater. Then they urged that seven hours of sleep should be common to all each night; that mental prayer should not exceed an hour, except for the examinations of conscience at their appointed time; that there should be an hour of rest after eating; that study should not be prolonged beyond two hours; that there should be time for a walk each week and other proper recreation."

Obviously these helpful physicians Ignatius consulted were reflecting concern for the "whole man" (spirit, mind, body). Their focus was on prevention and certainly not very far from Pelletier's contemporary emphasis on "giving patients information about diet, exercise, and life-style modification" in order to help them to "overcome disorders produced by daily activity, habits, and stress." You can hear their recommendations once again behind the founder's additional instruction: "In regard to food, clothing, living quarters and other bodily needs, although something should be done to test [the Jesuits'] virtue and self-abnegation, nevertheless, with the divine aid, care should be taken to avoid a lack of the things by which nature is sustained and preserved for God's service and praise."

Ignatius firmly believed that if his Jesuit followers could achieve through prayer intense union with God, they could then be effective instruments; He would use them through their apostolic efforts to further the coming of His Kingdom. In turn, Ignatius taught, they should be ready to make use of anything in the entire realm of creation that would help them to attain their goal—God's greater glory—through a loving, up-building service of their fellow men. Health, one can easily detect from the statements quoted above, was one of those created elements in a Jesuit's life that Ignatius felt should be cherished and developed as an apostolic asset. But he also wrote in the "Foundation" unit of his *Spiritual Exercises:* "We must make ourselves indifferent to all created things . . . we should not prefer health to sickness, riches to poverty, honor to dishonor, a long life to a short life." Here he was expressing the classical Christian theme, so important to him, that we should not become so attached to God's gifts that we cannot let go of them should He, in His Providence, take them away, or should they get in the way of our fulfilling the mission in life for which He created us.

HEALTH TODAY

So, like all gifts, a Jesuit should value his health, protect it, develop it, and use it as a means to accomplish his God-centered mission among his brothers and sisters in this world. This is what Ignatius seems to be telling his sons and all other religious persons whose spirituality draws upon his insights.

The fact that Ignatius invited a group of consulting physicians to help him assist his fellow Jesuits to achieve better health in their lives prompts me to wonder whom he would be calling upon today as spokesmen for the health-care professions. Surely, he would not ignore the alarming conditions that affect his men (and the men, women, and children they serve) all over the world today. At least not in the U.S., where the book *Executive Health* shockingly reminds us that "coro-

"Coronary disease has increased 500 percent in the last 50 years . . . ten percent of American males now aged 45 will not make it to 55."

nary disease has increased 500 percent in the last 50 years. An estimated 30 million Americans have some form of major heart or blood-vessel disease. An estimated one million have heart attacks each year. Of those, 650,000—including 200,000 between ages 45 and 65—die. Approximately one of every five men will have a coronary attack before age 60. For every death due to industrial accidents, there are 50 for cardiovascular disease. About 25 million Americans have hypertension (high blood pressure). An estimated eight million Americans have ulcers. Ten thousand die each year of hemorrhages or abdominal perforations that result from peptic ulcers. Approximately one in every eight persons suffers with migraine headaches at some time. Twelve million Americans are said to be alcoholics. Approximately ten million are diabetics. Americans consume 16,000 tons of aspirins each year, at an expenditure of approximately 500 million dollars. More than 230 million prescriptions are filled each year, including five billion doses of tranquilizers, three billion doses of amphetamines, and five billion doses of barbiturates. Ten percent of American males now aged 45 will not make it to 55."

FITNESS AND HEALTH

These are facts related to what have sometimes been called the diseases of civilization, the stress-related illnesses that June Goodfield of Rockefeller University well describes as "diseases of choice." She writes: "There is something distasteful in the sight of a highly developed society being forced to divert great resources, both financial and intellectual, to the cure of its own self-inflicted diseases. We can characterize these as diseases of choice—those which arise from excesses in its life-style, or the pollution of its environment."

In such a situation as ours, it would take very little imagination to picture Ignatius bringing together a group of experts who would offer their advice to religious people (Jesuits and all others) who are serious about preventing unnecessary illness and death as well as promoting what an Ignatius-influenced person might term "apostolic health."

What Ignatius would want for his men today, I would think, is what many health specialists call fitness. The condition is described in *The Complete Book of Walking* by Charles Kuntzleman, a YMCA consultant: "We're concerned with fitness, not sports. Fitness means improved heart-lung function that will help you get through the day without excessive fatigue. Fitness means control of your body weight. It also implies reducing the risk of coronary heart disease and making you feel better. In other words, the goal of fitness is to help you achieve better health and well being."

EXERCISING THE CARDIOVASCULAR SYSTEM

What is not immediately apparent from the term fitness itself is the fact that the body state it describes is principally that of the cardiovascular system. A fit person is essentially one whose body is in such good condition that he or she can exercise vigorously for a long period of time without fatigue and can respond to sudden physical and emotional demands with an economy of heartbeats and only a modest rise in blood pressure. A recent publication of the American Heart Association states, even more clearly, "The fit individual has endurance or stamina, and he is able to supply more energy to his muscles so that they can work harder and longer, and with less effort, than when he was not physically fit. Thus, when fit, the exerciser puts less strain on his cardiovascular system. He feels better, sleeps better and supposedly has improved digestion and disposition."

But to whom would Ignatius, or we for that matter, turn today to get expert advice about the means of achieving this fitness? No one could be more helpful, I suspect, than Dr. Kenneth Cooper of Dallas, leader of a U.S. Air Force research group. He wrote his first book, *Aerobics*, about ten years ago "to encourage people to examine more closely the benefits to be gained from regular exercise." (The prescription sounds Ignatian!) These benefits have not been widely sought or acquired in this country, Cooper complains. "In the U.S., where the vast majority of the population can't pass a basic fitness

test, we've got a long way to go in public sponsorship of exercise programs." But not just any form of exercise, no matter how regularly performed, will do.

One could participate frequently in a wide variety of athletic activities and still not become fit. What is essential is that the cardiovascular system be challenged. That means only those exercises that significantly increase the continuous flow of blood through the heart and large skeletal muscles will do. Even strenuous lifting does not suffice, because tensed muscles squeeze the blood vessels in such a prolonged way that blood is decreased rather than augmented. Swimming, on the other hand, involves rhythmic tensing and relaxing of muscles, which aids the flow of blood and does promote cardiovascular fitness. Only exercises that are rhythmic, repetitive, and include motion can improve stamina or endurance. But something more is required. Cooper maintains that fitness can never be achieved unless an exercise is kept up for a sufficiently long period of time. Sprinting would be useless; fatigue sets in too quickly. Any form of physical activity, if it is to qualify as fitness-producing, must be one that steadily supplies enough oxygen to the exercising muscles for as long as the exercises continue. That is the meaning of an exercise to be aerobic. (Sprinting does not supply enough oxygen—the reason why we have to quit so soon and why it cannot be regarded as aerobic.)

To qualify as fitness-producing, a physical activity must supply enough oxygen to the exercising muscles for as long as the exercises continue.

BENEFITS OF AEROBIC EXERCISE

Swimming, bicycle riding, and walking are good examples of aerobic exercise that can be sustained for long periods of time and more or less effortlessly, because a balance can be achieved between the oxygen the person needs and the oxygen he is actually getting through his lungs and cardiovascular system. Cardiologist Lenore Zohman explains: "Any rhythmic, repetitive, dynamic activity which can be counted for two or more minutes, without huffing and puffing afterwards, is probably aerobic. If enough oxygen were not being provided to the muscles, the exercise could not be continued . . . ." But it is possible to swim, walk, or ride a bicycle for long periods of time and for great distances without really challenging the cardiovascular system. Stamina, endurance and fitness can only be achieved when one frequently exerts oneself in such exercises to the point where hard work is being done for a considerable period of time and a lot of oxygen is being demanded.

Cooper maintains that the principal objective of any program of aerobic exercise is to increase the maximum amount of oxygen that the body can process in a given time. This is called an individual's aerobic capacity. It is dependent upon an ability to rapidly breathe large amounts of air, forcefully pump large volumes of blood, and effectively deliver oxygen to all parts of the body. In other words, efficient lungs, a powerful heart, and a good vascular system are required. But, Cooper insists, "unless the exercise is of sufficient intensity and duration, it will not produce a training effect (i.e., beneficial changes in the various systems and organs of the body) and cannot be classified as an aerobic exercise." His books, *Aerobics* and *The New Aerobics*, provide clearly and encouragingly all the information needed to undertake and accomplish safely a course of aerobic exercises. The programs he outlines in the more recent book are graded and adjusted for both men and women within various ranges of age.

What benefits could you expect to derive from an aerobic program you might select for yourself? Dr. Samuel Fox, past president of the American College of Cardiology, assures his readers that aerobic exercises faithfully performed on a regular basis might do all of the following: "(1) increase the number and size of your blood vessels for better and more efficient circulation; (2) increase the elasticity of the blood vessels and thereby reduce the likelihood of their breaking under pressure (as happens in some strokes); (3) increase the efficiency of exercising muscles and blood circulation so that muscles and blood are better able to pick up, carry, and use oxygen; (4) increase the efficiency of the heart, making it able to pump more blood with

fewer beats and better able to handle emergencies; (5) increase tolerance to stress and give you more joy of living; (6) decrease triglyceride (fat) and cholesterol levels so as to reduce the likelihood of fats being deposited on the lining of the arteries; (7) decrease clot formation so there is a smaller chance of a blood clot forming and blocking blood flow to the heart muscle; (8) decrease blood sugar, reducing changes of blood sugar being changed into triglycerides; (9) decrease obesity and high blood pressure, which is good since most people who are obese and have high blood pressure are more prone to heart disease; (10) decrease hormone production—good because too much adrenaline can cause problems for the arteries."

While we are still considering aerobic exercise in a general way, it should be pointed out that different specific forms of physical activity make different contributions to our health. The President's Council on Physical Fitness and Sports asked seven exercise experts to rank some popular types of physical activity according to the degree they contribute to cardiorespiratory endurance, muscular endurance, muscular strength, flexibility, balance and general well-being. The table below summarizes their findings.

EIGHT SPORTS: HOW MUCH THEY HELP WHAT

PHYSICAL FITNESS	*RUNNING*	*BICYCLING*	*SWIMMING*	*HANDBALL/ SQUASH*	*TENNIS*	*WALKING*	*GOLF*	*BOWLING*
CARDIO-RESPIRATORY ENDURANCE	21	19	21	19	16	13	8	5
MUSCULAR ENDURANCE	20	18	20	18	16	14	8	5
MUSCULAR STRENGTH	17	16	14	15	14	11	9	5
FLEXIBILITY	9	9	15	16	14	7	8	7
BALANCE	17	18	12	17	16	8	8	6
GENERAL WELL-BEING								
WEIGHT CONTROL	21	20	15	19	16	13	6	5
MUSCLE DEFINITION	14	15	14	11	13	11	6	5
DIGESTION	13	12	13	13	12	11	7	7
SLEEP	16	15	16	12	11	14	6	6
TOTAL	**148**	**142**	**140**	**140**	**128**	**102**	**66**	**51**

The question arises as to how many calories an average person burns while engaging in those various activities for an hour. *The Complete Book of Running,* by James F. Fixx, provides the following figures: Running, 800 to 1,000 calories; bicycling (at 13 miles per hour), 660; swimming, 300 to 650; handball/squash, 600; tennis 400 to 500; walking briskly (at 4 miles per hour), 300; bowling, 270; golf, 250; walking slowly (at 2 miles per hour), 200.

These figures suggest that if a person's motivation to exercise comes from a desire to lose weight, the precise type of activity selected might make a big difference in the outcome. But there are other motives that prompt people (including 25 million Americans who jog) to undertake and continue a fitness program of some sort. Some do it out of fear of ill health; others expect (rightly) to look and feel better. The pleasure principle brings many people to exercise in ways they find enjoyable as recreation. Desire to share athletic experiences with family members or friends provides powerful incentives for people of all ages. And, it must be admitted, the need to participate in whatever is in vogue drives some people into action—but generally not for long. Not all who exercise, of course, take on programs that are aerobic. There will always be people who aim simply at developing certain muscles or athletic skills. But no matter what type of exercise regimen is intended, at least half the battle toward accomplishing a goal resides in summoning up from somewhere the motivation that is—strictly speaking—a sine qua non.

No matter what type of exercise is intended, half the battle resides in summoning up the motivation that is —strictly speaking— a sine qua non.

DETERMINING OVEREXERTION

For many people beginning an exercise program, there is frequently a tendency to overexert themselves. A few signs should be kept in mind in order to know when to stop exercising at once and rest: a feeling of tightness or pain in the chest; severe breathlessness; lightheadedness; dizziness; losing control of muscles; nausea. Failure to heed these warning signs has often resulted in death.

Cooper has suggested a useful way to determine whether you are exercising too hard by checking your recovery heart rate. After exercising, wait five minutes, then take your pulse. (If you can't find your wrist pulse, just put your palm over your throat and check it there.) Using a watch or clock with a sweep-second, count your pulse for 10 seconds. Now multiply by 6. You have your pulse rate. (You could also count your pulse for 15 seconds and multiply by 4.) When are you exercising too hard? When your pulse rate goes above 120. In that case, resolve to go at it a little easier next time around.

Another useful sign of overexertion is this one: Check your pulse 10 minutes after you've stopped exercising; if it is above 100, you're going at it too intensely. Cut back a little next time.

Your breathing rate response provides yet another safety check. If you are short of breath 10 minutes after exercising, your activity level is too strenuous. Take it easier next time. The normal breathing rate, as a basis for comparison, is 12 to 16 breaths a minute.

Cooper has prepared a list of medical conditions that absolutely prohibit a person's participation in any form of exercise program. They include the following:

- Moderate to severe coronary heart disease that causes chest pain (angina pectoris) with minimal activity.
- Recent heart attack. A three-month waiting period is mandatory before you start on a regular conditioning program, and even then any conditioning must be medically supervised.
- Severe disease of a heart valve, primarily the result of having rheumatic fever at an early age. Some patients with this condition shouldn't exercise at all, not even to the extent of walking fast.
- Certain types of congenital heart disease, particularly those in which the body's surface turns blue during exercise.
- Greatly enlarged heart resulting from high blood pressure or other types of progressive heart disease.
- Severe heartbeat irregularities calling for medication or frequent medical attention.

- Uncontrolled sugar diabetes constantly fluctuating between too much and not enough blood sugar.
- High blood pressure not controlled by medication—for example, readings of 180/110 even with medication.
- Obesity. If you're more than 35 pounds overweight according to standard charts, you must lose weight on a walking program before you can begin anything more strenuous like jogging or running.
- Any infectious disease during its acute stage.

WHEN IS A DOCTOR REQUIRED?

There are other ailments that do not forbid exercise but that do call for a doctor's supervision of the program undertaken. The kind and quality of exercise should be decided by the person's physician. These medical conditions, as outlined by Cooper, include:

- Any infectious disease in its convalescent or chronic stage.
- Sugar diabetes controlled by insulin.
- Internal bleeding, recently or in the past (in some cases, exercise is not permitted at all).
- Kidney disease, either chronic or acute.
- Anemia under treatment but not yet corrected (less than 10 grams of hemoglobin).
- Lung disease, acute or chronic, that causes breathing difficulties even with light exercise.
- High blood pressure that can be reduced only to 150/90 with medication.
- Blood vessel disease of the legs that produces pain with walking.
- Arthritis in the back, legs, feet, or ankles, requiring frequent medication to relieve pain.
- Convulsive disease not completely controlled by medication.

HOW MUCH, HOW LONG, HOW OFTEN?

For a person who is physically out of shape yet inclined to undertake a conditioning program, Cooper has provided some guidelines that bear careful observance. First, age restrictions:

Up to 30 years of age: Unless you have some obvious medical problem, you can enter any type of exercise program—running, jogging, swimming, cycling, etc.—no restrictions.

Between 30 and 50: You still have your choice of sports. But if you plan to do some more strenuous exercises, be sure to get your doctor's specific approval of your decision.

Between 50 and 59: It would be better if you started a walking program. Only after you have conditioned yourself by walking should you consider running, jogging, or more demanding competitive sports such as basketball, hardball, or squash. Have your doctor check you out again before you start such activities. Otherwise, you are better off starting with less arduous exercises such as walking, golf, cycling (particularly stationary cycling), and swimming.

Age 60 and over: If you're like most people in this age group, avoid jogging, running, and vigorous competitive sports. Walking, swimming, and stationary cycling will do you a lot more good.

Cooper allows an exception to one group of persons in the over-60 bracket. If they have stayed in shape by regular exercise for many years, so that they have built up and maintained their aerobic capacity, they may safely participate in such vigorous activities as jogging, running, and stationary running. They are also permitted to engage in even more strenuous activities if they do their exercising in a group that is being medically supervised.

Whatever your age, it is mandatory that you have medical supervision in connection with your exercise program. There have been far too many casualties among people who thought they were in very good health but who actually were living at the time with a concealed medical problem. Again, Cooper makes the following recommendations:

Under 30: If you have had a medical checkup in the past year and received a clean bill of health, you can start any time.

30 to 39: The medical history and physical examination should have taken place within the past six months.

40 to 49: The history and examination should have taken place in the past three months and should have included an electrocardiogram (ECG) taken while resting.

Over 50: Same as 40 to 49, except the examination should be given immediately before starting into an exercise program and should include an ECG while exercising. Your pulse rate should reach the level that is expected during strenuous aerobic exercise.

THE VALUE OF "TRAINING" (AEROBICALLY)—
as estimated by author James F. Fixx

When we train, a number of adaptations take place in our bodies. Among them are these:

- We increase our capacity for using oxygen.
- Our hearts are able to pump more blood at a lower pulse rate and blood pressure.
- Our lung capacity increases.
- Our heat-dissipating ability increases.
- After exercise, our pulse rate and blood pressure return to normal more quickly.
- We develop greater muscular strength.
- We produce less lactic acid—a work limiting substance—for a given amount of work.
- Our bodies become more efficient mechanically, using less oxygen per unit of work.
- We develop greater endurance.

How often must you exercise to derive the beneficial cardiovascular training effect from a program of aerobic exercises? Most cardiologists recommend at least three times a week, and no more than two days should elapse between workouts. How long should the periods of exercise last on these days? The answer to that question depends on the type of exercise you are doing. How, then, do you know what form of exercise is best for you? Perhaps no one can give you the right answer. You may have to try several forms of exercise and see which one meets your needs and feels best to you.

If Ignatius were on the scene today, he would probably be wondering whether it would be a good idea to recommend to all his Jesuit brethren—for the sake of their cardiovascular fitness, general health, and apostolic effectiveness—that they consider taking up jogging. His search for an answer would undoubtedly bring him into contact with one of the world's leading spokesmen for all recreational runners, Jim Fixx. Just as he described it for his readers in *The Complete Book of Running*, Fixx would undoubtedly recount for Ignatius the experience of his own conversion to jogging: "But even more interesting (than learning to run) were the changes that had begun to take place in my mind. I was calmer and less anxious. I could concentrate more easily and for longer periods. I felt more in control of my life. I was less easily rattled by unexpected frustrations. I had a sense of quiet power, and if at any time I felt this power slipping away, I could instantly call it back by going out and running. Every runner is familiar with these changes."

Fixx has found that the changes running has produced in his own life and in others have been physical, social, mental, even spiritual. He suggests the following as some of his reasons for running:

> fitness; fun; feeling good; a lot of exercise in a relatively short time; the option of making it competitive or noncompetitive; a good family sport; a democratic, egalitarian, unsnobbish activity; an antidote to many of the hazards of twentieth-century living; loss of weight; look better and feel better; reduction of the risk of developing coronary heart disease; tension headaches disappear; remain physiologically young; improved physical vigor; heightened sexual pleasure; possible lengthening of life; a sense of enhanced mental energy and concentration; a feeling of heightened mental activity; development of ability to apply effort during extreme fatigue; ability to accept pain; a sense of controlling one's own life; a relief of tension; improved sense of worth; a sense of freedom to go at your own speed where you want and think your own thoughts; an antidote to anxiety and depression; improvement in morale; more emotionally stable, more self-sufficient, more imaginative, and more confident; more spiritual; lessons in human limits, and about personal wholeness and integrity; diminished tendency to smoke and drink; learning to control aggression; fulfills the human need for movement, self-assertion, alternations of stress and relaxation, mastery over ourselves; to indulge ourselves, to play, to lose ourselves in something greater than ourselves; to meditate; and to live to our own rhythms.

How much running does it take to accomplish all these? Forty-five minutes or an hour of running or jogging at least four days a week, Fixx claims. "It takes that much running for its insistent, hypnotic rhythms to induce what some runners describe as a trancelike state, a mental plateau where they feel miraculously purified and at peace with themselves and with the world." Fixx's book, which is extremely interesting as well as encyclopedic, promises a lot to the prospective jogger or runner. We read in the preface: "If you are not yet a runner, it will show you how to become healthier and happier than you have ever imagined you could be. It will do so no matter how out of shape or fat or old or ungraceful you are, and no matter how many times you have tried and failed." That's a lot to hope for as a result of just a little reading and then regular road work. But tens of thousands of his readers claim they have followed his masterful advice and have not been disappointed.

WALKING AND RUNNING

You may have noticed that Fixx refers consistently to running rather than jogging. He does so in his writings deliberately, as do most others who promote physical fitness. Their reason is because

Walking has been credited with relieving depression, lowering blood pressure, reducing weight, preventing varicose veins, and reducing anxiety.

there is no particular speed at which jogging turns into running. "If you feel that you are running, no matter how slow you are going, no one can say you are not," reasons Fixx. It has been estimated that in the general population only 10% to 15% of children and adults are natural runners who will stay with the program they begin. "Others," says Dr. George Sheehan, a runner himself, "who are more athletic and muscular will run only as part of another sport. Those who tend to be more broad than long will not run at all. Sport to them is walking, cycling, skating, skiing, or swimming." Despite the opportunity to participate in a wide variety of sports, including those Sheehan mentions, people who want to exercise aerobically generally prefer jogging or running. In only 20 minutes, three times a week, they can get enough exercise to maintain their fitness. Other activities take considerably more time (counting travel to the gym, pool, etc.) to achieve a comparable training effect. Running takes less equipment, too; in fact, practically none. The cost of proper shoes has been estimated as just about one cent a mile.

But what about walking? Would someone as knowledgeable and enthusiastic about the subject as Kuntzleman be able to sell this conventional form of exercise to Ignatius today—or to other religious persons who want to remain fit physically as well as spiritually for the sake of their apostolate? He certainly presents a convincing argument in *The Complete Book of Walking*. Arguing that walking, if you do it fast enough, is an aerobic exercise, he maintains that almost anyone can do it; no "fancy paraphernalia, fees or instructors are required"; and a walk can be very easily fitted into your daily schedule on a regular basis. Kuntzleman states that people who are overweight, afflicted with arthritis or emphysema, and those who have heart disease (even those who had coronary attacks) can safely and profitably enjoy the benefits of walking. The fact that walking is a low-sweat activity also recommends it.

Walking has been credited with relieving depression, lowering blood pressure, reducing weight without the danger of drugs or a crash diet, preventing varicose veins, reducing anxiety and tension (as a natural tranquilizer), and allowing the participant—alone or with a companion—to observe the beauty of the environment, to be curious, reflective, and prayerful. Oliver Wendell Holmes recommended it well when he wrote: "In walking, the will and the muscles are so accustomed to working together and perform their task with so little expenditure of force that the intellect is left comparatively free." If you want to use your mind while walking, you will be in good company. Hippocrates, Aristotle, Demosthenes, Lincoln, Thoreau, Einstein—all lend credence to cardiologist Paul Dudley White's prescription: "A minimum of an hour a day of fast walking is absolutely necessary for one's optimal health, including that of the brain." Perhaps the best proponent of habitual walking for the sake of total fitness is historian George Trevelyan, who observed: "I never knew a man to go for an honest day's walk for whatever distance, great or small . . . and not have his reward in the repossession of his soul."

In his new book, *The Culture of Narcissism*, a most scathing and profound commentary on our American society, Christopher Lasch contends: "The contemporary climate is therapeutic, not religious. People today hunger not for personal salvation, let alone for the restoration of an earlier golden age, but for the feeling, the momentary illusion, of personal well-being, health, and psychic security." To foster the type of narcissistic self-absorption that Lasch deplores is certainly not the intention of the writer of this article. My aim in presenting these thoughts about health, fitness, exercise, running, and walking could best be described, I believe, as apostolic. We who have been called to ministry have been sent to deliver the good news of salvation to the whole world. It's a big world, and there are too few of us; stamina and endurance are essential. Exercises that are physical will serve to build a platform to support those that are spiritual. But both are expedient—I know Ignatius would agree. Not just for holistic health but for the greater glory of our God.

Book Review

Growth Counseling, by Howard Clinebell. Abingdon, Nashville, 1979, 208 pp., $7.95.

DON SUTTON, S.J.

Dr. Howard Clinebell, professor of pastoral counseling at the School of Theology at Claremont, California, offers his readers an interesting and potentially useful guide to counseling and direction in pastoral/ministerial settings. His complex aim is to present a system that will enable you to experience the liberating impact of the "growth perspective" as a way of seeing yourself and others and the "hope perspective" as a means of facilitating growth; to encourage you to develop your own rich, unfolding possibilities; to increase your joy in being alive and in becoming the fuller person you have the potential to become through each life stage; to set forth in a clear and useful way the basic principles and methods of growth counseling; encourage you to develop your own style of growth-enabling counseling and therapy; and to make you more aware that spiritual growth is central to all human growth and is therefore an essential part of your task as a counselor or therapist.

Do not be put off by the self-help or cure-all sound of these words. The author recognizes that the world is imperfect and that life can be enjoyed anyway. He wishes to give us a comprehensive picture of his system and in the process sometimes idealizes it a bit. But that does not diminish the value of his presentation, which is at once theoretical and practical, philosophical and pragmatic. He attempts to elaborate his own world view and philosophy of the human person, because he feels it is essential for the counselor to be in touch with the value system regarding people that colors the work he or she is doing. Clinebell's is clearly a positive, optimistic picture, as can be seen from his definition of growth counseling. It is an approach to the helping process that defines the goal as that of facilitating the maximum development of a person's potentialities at each life stage in ways that contribute to the growth of others and to the development of a society in which all persons can use their full potentialities.

But, he says, growth counseling is much more than a set of techniques. It is, at its heart, a basic orientation toward people—a growth- and hope-centered way of perceiving, experiencing, and relating to them.

Still, Clinebell is not naive. He examines the reality of evil, both personal and societal. He discusses the phenomenon of existential anxiety and the role religion can (and must) play in alleviating it. He presents a chapter on the use of his theory in a developmental model, relating it to the work of Erikson, Kohlberg, and Fowler.

The book is full of practical suggestions as well. There are verbatim condensations that illustrate the theory, and there are exercises at the end of chapters to enable the reader to experience the process firsthand with others. The author offers some questions that he calls value-reformulation exercises and other questions that invite people to open the spiritual dimension of their lives to reflection in times of loss or tragedy.

Among his theoretical insights, Clinebell suggests six dimensions (all interdependent) within which growth can occur: in our minds, in our bodies, in our relationships with other people, with the biosphere, with the groups and institutions that sustain us, and in the spiritual dimension of our lives. His analysis of the interdependencies is valuable. Also, he offers the reader criteria for differentiating salugenic (health- and growth-producing) from pathogenic religion. For example, do a person's belief and practice give a meaningful philosophy of life that provides hope in the face of tragedy? Does it provide creative values and ethical sensitivities? Does it stimulate the growth of inner freedom and harmony? In its entirety, it is a fairly complete list that should be very useful to a director or counselor in assessing the current state of an individual with regard to the role religion is playing in that person's life.

The chapter on "Biblical and Theological Resources for Growth Counseling" is an interesting presentation supporting the growth process with a biblical base, and will prove valuable and informative to those interested in the complement between religion, Scripture, and the growth movement. "Toward a Whole Theology" is a positive reminder to avoid sexism. It urges theologians not only to an avoidance of sexism, but also to a nurturing of the "soft, vulnerable, feelingful side" of personality, which is a frequent theme of Clinebell's.

At times, the book suffers from psychobabble; for example, "potentializing," "a growing gift," "lay growth enablers." Although I was mildly distracted by such lapses, the author more than redeems himself by presenting a system of counseling that calls the counselor to as much honesty and growth as it does the counselee and attempts to draw them both into a self-transcendent and global world view. Such lofty goals can never be achieved in a single volume, but this book makes a worthwhile contribution to the effort.

Don Sutton, S.J., is a student at Weston School of Theology, Cambridge, Massachusetts, and holds a Ph.D. in psychology from St. Louis University.

HUMAN DEVELOPMENT